


Medical Care Form

Claim number :wefwef

| 1. Health Insurance System Information | | | Filling Instructions | | |
|--|----------------------------------|----------------------------|----------------------|------|-----------------------------------|
| SAM code: | | | Write legibly | | |
| SAM: | | | ID obligatoire | | |
| Information & Access To Health Care | | | 2. Patient Policy | | 3. Infos Reference Medical Center |
| Primary insured | Matricule: | | | | Date and Time: |
| | Nom: | Suyesh 15151 2023-09-02 | | | Agreed healthcare network: |
| Patient | Carte ID: | 22 | | | |
| | Full Name (first, middle, last): | Suyesh 15151 2023-09-02 | | | |
| | Age: | 0.3 | | | Prescribing Doctor / orientation: |
| | Marital Status : | | | | |
| | Gender : | Male | | | |
| 4. Details Of Medical Procedures: | | | | | |
| Date | Code | Designation (Medical acts) | Coefficient | Rate | Total Cost |
| | | | | | |
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| | | | |
|---|---------------------------|-------------------------------------|--|
| <u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue | Total amount: | | |
| | To be paid by the patient | | |
| Assignment code | | To be paid by the insurance company | |

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|---|-------|---|-------------------------------------|-----------------------------------|-----------------------------------|--|
| Information & Access To Health Care | | | 2. Patient Policy | | 3. Infos Reference Medical Center | |
| | | | | | | |
| <u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue | | | Total amount: | | | |
| | | | To be paid by the patient | | | |
| Assignment code | | | To be paid by the insurance company | | | |
| 5. Details Of Paramedical Procedures: | | | | | | |
| Date | Code | Designation (Medical acts) | Coefficient | Rate | Total Cost | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| <u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue | | | Total amount: | | | |
| | | | To be paid by the patient | | | |
| Assignment code | | | To be paid by the insurance company | | | |
| Patient signature | | Signature and stamp medical Healthcare centre | | Signature and stamp of the Doctor | | |
| 6. Medicines Prescribed (Section Reserved For Doctor) | | | Section Reserved For The Pharmacist | | | |
| No: | Drugs | Dosage | Quantity | Total Cost | | |
| 1 | | | | 2500 | | |
| <u>Important:</u> The prescribing | | Total amount: | | 2500.00 | | |
| | | | | | | |

| | | |
|--|--|---|
| <p>practitioner will</p> <p>Prescribed (Section Reserved For</p> <p>indicate the duration of treatment for</p> <p>each</p> <p>Doctor)</p> <p>drug,</p> | <p>6. Medicines</p> <p>The</p> <p>Prescribing</p> | <p>Section Reserved</p> <p>For The Pharmacist</p> |
| <p>this form is valid only for one pharmacy</p> <p>and</p> <p>its</p> <p>validity cannot exceed 72 hours after</p> <p>delivery</p> | <p>To be paid by</p> <p>the patient (%)</p> | <p>1650.00</p> |
| | <p>To be paid by</p> <p>MAADO</p> | <p>850.00</p> |
| <p>Signature and stamp Prescribing Doctor</p> | <p></p> <p>Signature and stamp Pharmacist</p> | |