Medical Care Form

Claim number:123

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care			3. Infos Reference Medical Center			
Matricule:			Date and Time:			
Nom:	prashant 2005-02-01		Agreed healthcare network:			
Carte ID:	2					
Full Name (first, middle, last):	prashant 2005-02-01					
Age:	18.6		Prescribing Doctor / orientation: 12 12 12			
Marital Status :						
Gender :	Male					
edical Procedures:						
k ode	Designation (Medical acts)		Coefficient	Rate	Total Cost	
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status :	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Age: 18.6 Marital Status: Gender: Male edical Procedures: Code Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 2005-02-01 Carte ID: 2 Full Name (first, middle, last): Age: 18.6 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Parashant 2005-02-01 Full Name (first, middle, last): Age: 18.6 Prescribing Docto 12 12 12 Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Prashant 2005-02-01 Full Name (first, middle, last): Age: 18.6 Prescribing Doctor / orien 12 12 12 Marital Status: Gender: Male Designation (Medical Coefficient Rate	

<u>lmportant:</u> The validity of this form cannot e	Total amount:		
date of issue		To be paid by the patient	
Assignment code		To be paid by the insurance company	

nformation & Access To Health Care			2. Patient Policy		3. Infos Reference Medical Center			
<u>Import</u>	tant: The validit	y of this form cannot e	exceed 5 days	from the		Tota	al amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by the insurance company				
			5. Det	ails Of Pa	aram	edical Procedu	ıres:	
Date	Code	Designation (Medical acts)		Coefficient		Rate	Total Cost	
Important: The validity of this form cannot exceed			exceed 5 days			Total amount:		
from t	he date of issue			To be	paid	by the patient		
Assignment code				To be pa	paid by the insurance company			
Pati	ent signature	Signature and stamp medical Healthcare centre Doctor			d stamp of the			
Prescribed (Section Reserved For The				Section Reserved For The Pharmacist				
Docto	r)			J				
No:	Drugs		Dosage	Quantity	Total	Cost		
1	Colchimax 01 n	ng comp	1	1	1			
		ne prescribing	Total am	nount:	1.00			

Prescrib each Doctor)	practitioner will ped (Section Reserved For indicate the duration of treatment for drug,	6. Medicines The Prescribing	Section Reserved For The Pharmacist
and	this form is valid only for one pharmacy	To be paid by the patient (%)	0.98
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	0.02
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist