Medical Care Form

Claim number:4f34f34f

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
SAM:			ID obligatoire				
Information & Access To Health Care		2. Patient	3. Infos Reference Medical Center				
Matricule:	Suyesh 15151 2023-09-02		Date and Time:				
Nom:			Agreed healthcare network:				
Carte ID:	22						
Full Name (first, middle, last):	Suyesh	15151 2023-09-02					
Age:	0.3		Prescribing Doctor / orientation: Otis MillBurn				
Marital Status :							
Gender :	Male						
4. Details Of Medical Procedures:							
Loge	Designation (Medical acts)		Coefficient	IRate	Total Cost		
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status : Gender : Edical Procedures:	Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: O.3 Marital Status: Gender: Male Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Suyesh 15151 2023-09-02 Carte ID: 22 Full Name (first, middle, last): Age: 0.3 Marital Status: Gender: Male dical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Suyesh 15151 2023-09-02 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: O.3 Prescribing Docto Otis MillBurn Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Suyesh 15151 2023-09-02 Agreed healthcare networ Carte ID: 22 Full Name (first, middle, last): Age: 0.3 Prescribing Doctor / orient Otis MillBurn 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	

Information & Access To Health Care		2. Patient Policy			. Infos Referen enter	ce Medical			
Important: The validity of this form cannot exceed			eed 5 days f	rom the		Tota	ıl amount:		
date of issue						-	To be paid by the patient		
Assignment code				i			To be paid by the insurance company		
	5. Details Of Paramedical Procedures:							ıres:	
Date	Date Code Designation (Medical acts)		s)	Coefficient Rate		Rate	Total Cost		
<u>Important:</u> The validity of this form cannot exceed			eed 5 days			Total amount:			
from the o	from the date of issue				To be	e paid	by the patient		
Assignment code				To be paid by the insurance company					
Patient signature Signature and stamp medical Hea			edical Healt	Signature and stamp of the Doctor					
Prescribed (Section Reserved For Tl			6. Med The Prescr	Section Reserved For The Pharmacist					
No:	Drugs Dosage		Dosage	(uantity	Total	al Cost			
1						25			
<u>lr</u>	Important: The prescribing			Total am	ount:	25.00			

Prescrik 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 (%)	16.50	
		To be paid by MAADO	8.50	
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist		