Medical Care Form

Claim number:wsws

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:	VVVV Fna 1937-12-30		Agreed healthcare network:			
Carte ID:	549050					
Full Name (first, middle, last):	VVVV Fna 1937-12-30					
Age:	85.9		Prescribing Doctor / orientation:			
Marital Status :						
Gender :	Female					
edical Procedures:						
(OUE	Designation (Medical acts)		Coefficient	Rate	Total Cost	
	Access To Health Care Matricule: Nom: Carte ID: Full Name (first, middle, last): Age: Marital Status: Gender: edical Procedures:	Access To Health Care Matricule: Nom: VVVV Fr Carte ID: 549050 Full Name (first, middle, last): Age: 85.9 Marital Status: Gender: Female edical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: VVVV Fna 1937-12-30 Carte ID: 549050 Full Name (first, middle, last): Age: 85.9 Marital Status: Gender: Female edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: VVVV Fna 1937-12-30 Full Name (first, middle, last): Age: Age: Besignation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: VVVV Fna 1937-12-30 Carte ID: Full Name (first, middle, last): Age: Age: 85.9 Prescribing Doctor / orien Marital Status : Gender : Female Policy Carte ID: Code 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		ference Medical	
<u>Important</u>	<u>::</u> The validit	y of this form cannot e	exceed 5 days 1	from the		Total amount:
date of iss	sue				To be pai	d by the patient
Assignment code				To be paid by th insurance compar		o be paid by the Irance company
			5. Det	ails Of Pa	ramedical Pr	ocedures:
Date	Code	Designation (Medical acts)		Coefficier	nt Rate	Total Cost
Important: The validity of this form cannot exceed		exceed 5 days		Total am	ount:	
from the o	date of issue			To be ¡	paid by the pa	atient
Assignment code				To be paid by the insurance company		
Patient signature Signature and stamp medical Healtho			thcare cer	Signature and stamp of the Doctor		
6. Med Prescribed (Section Reserved For The Presc Doctor)			dicines ribing	Section Reserved		
No:	Dr	ugs	Dosage	QuantityTo	otal Cost	
1		P333333		4		
			Total am	ount: 4	.00	
Important: The prescribing			-			

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 (%)	2.64
		To be paid by MAADO	1.36
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist