Medical Care Form

Claim number:sfdfsdf

| 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: | Laura Marhysa 1978-01- 20 | | Date and Time: | | | | |
| Nom: | | | Agreed healthcare network: | | | | |
| Carte ID: | 594565 | | | | | | |
| | Laura Marhysa 1978-01- 20 | | | | | | |
| Age: | 45.8 | | Prescribing Doctor / orientation: dhiraj gurve | | | | |
| Marital Status : | | | | | | | |
| Gender : | Female | | | | | | |
| edical Procedures: | | | | | | | |
| Code | 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: Carte ID: Full Name (first, middle, last): Age: Age: 45.8 Marital Status: Gender: Female edical Procedures: Designation | Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Marital Status: Gender: Female edical Procedures: Designation (Medical | Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Laura Marhysa 1978-01-20 Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Prescribing Doctodhiraj gurve Marital Status: Gender: Female Designation (Medical Coefficient | Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Laura Marhysa 1978-01-20 Carte ID: 594565 Full Name (first, middle, last): Age: 45.8 Prescribing Doctor / orien dhiraj gurve Marital Status: Gender: Female 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 nter | ce Medical | | |
|---|-----------------------|----------------------------|----------------------|--|--------------------------------|---------------------------|------------|--|
| | | | | | | | | |
| <u>Important</u> | <u>::</u> The validit | ty of this form cannot e | exceed 5 days | from the | | Tota | ıl amount: | |
| date of issue | | | | | | To be paid by the patient | | |
| Assignment code | | | | To be paid by the insurance company | | | | |
| | | | 5. Det | ails Of Pa | ırame | dical Procedu | ıres: | |
| Date | Code | Designation (Medical acts) | | Coefficie | nt | Rate Total Cost | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| <u>Important:</u> The validity of this form cannot exceed | | | exceed 5 days | | 7 | Γotal amount: | | |
| from the o | date of issue | e | | To be | paid k | by the patient | | |
| Assignment code | | | | To be pa | id by the insurance company | | | |
| Patient signature Signature and stamp medical Heal | | | thcare ce | Signature and stamp of the Doctor | | | | |
| Prescribed (Section Reserved For The | | | dicines | Section Reserved For The Pharmacist | | | | |
| No: | Dr | ugs | Dosage(| QuantityT | otal C | Cost | | |
| 1 | | | | 3 | 30000 | | | |
| | | h | Total am | ount: 3 | 30000. | 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 (%) | 29400.00 |
| | | To be paid by MAADO | 600.00 |
| Sigi | nature and stamp Prescribing Doctor | Signa | ture and stamp Pharmacist |