## **Medical Care Form**

Claim number:

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: mary			Date and Time:	ate and Time:			
Nom:			Agreed healthcare	e networ	·k:		
Carte ID:							
Age:			Prescribing Docto	r / orien	tation:		
Marital Status :							
Gender :							
4. Details Of Medical Procedures:							
K OOE	Designation (Medical acts)		Coefficient	Rate	Total Cost		
	Access To Health Care  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status :  Gender :	Access To Health Care  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status :  Gender :  edical Procedures:  Designation	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status :  Gender :  edical Procedures:  Code  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Prescribing Docto  Marital Status:  Gender:  Code  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Carte ID:  Full Name (first, middle, last):  Age:  Marital Status:  Gender:  Designation (Medical Coefficient Rate		

<u>Important:</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 Medica	al .	
<u>Importar</u>	nt: The v	/alidit	y of this form cannot e	exceed 5 days	from the		Tota	ıl amount:	
date of is	sue						To be paid by t	he patient	
Assignment code						To be paid by the insurance company			
				5. Det	ails Of Pa	ram	edical Procedu	ıres:	
Date	ate Code Designation (Medical ad		acts)	Coefficient		Rate	ate Total Cost		
<u>lmportar</u>	<u>ıt:</u> The v	/alidit	y of this form cannot e	exceed 5 days			Total amount:		
from the	date of	issue			To be	paid	by the patient		
Assignment code				To be paid by the insurance company					
Patient signature Signature and stamp			o medical Healthcare centre Doctor			the			
Prescribed (Section Reserved For  Doctor)			6. Med The Presci	dicines ribing	Section Reserved			erved	
No: Drugs		Dosage	QuantityT	uantity Total Cost					
			Total am	amount:					
Important: The prescribing practitioner will				To be paid by the patient (%)					

	ate the duration of treatment for ection Reserved For	6. Medicines The Prescribing	Section Reserved For The Pharmacist	
and its	ney cannot exceed / 2 nodis dice.	To be paid by MAADO		
Signature	e and stamp Prescribing Doctor	Signature and stamp Pharmacist		