Medical Care Form

Claim number: 324324

1. Health Insurance System Information			Filling Instructions					
SAM code:			Write legibly					
	ID obligatoire							
Access To Health Care		2. Patient Center Policy			al			
Matricule:			Date and Time:					
Nom:	Suyesh	15151 2023-09-02	Agreed healthcare network:					
Carte ID:	22							
Full Name (first, middle, last):	Suyesh	15151 2023-09-02						
Age:	0.3		Prescribing Doctor / orientation: dvfdvd fd dff					
Marital Status :								
Gender :	Male							
edical Procedures:								
l one	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: Suyesh Carte ID: 22 Full Name (first, middle, last): Age: O.3 Marital Status: Gender: Male edical Procedures: 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 edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Suyesh 15151 2023-09-02 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: O.3 Prescribing Docto dyfdyd fd dff 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 dvfdvd fd dff 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			3. Infos R Center	eferen	ce Medical		
Important: The validity of this form cannot exceed					exceed	d 5 days from the				Tota	ıl amount:
date of issue								To be paid by the patient			
Assignment code						To be paid by t insurance compa					
						5. Det	ails Of P	aram	nedical P	rocedu	ıres:
Date	Date Code Designation (Medical acts)			Coefficient		Rate		Total Cost			
Important: The validity of this form cannot exceed			exceed	l 5 days			Total ar	nount:			
from the date of issue						To be	e paid	d by the լ	oatient		
Assignment code					To be paid by the insurance company						
Patient signature Signature and stamp medical Healt						Signature and stamp of the Doctor					
Prescribed (Section Reserved For					6. Med The Presci	Section Reserved ribing For The Pharmacist					
No:	Drug	S				Dosage (Quantity	Tota	l Cost		
1	bucco	olam 1	10 mg,	solution buccale		423 2	22	814			
					-	Total an	nount:	814.0	00		
Important: The prescribing			ŀ								

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 (%)	537.24
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	276.76
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist