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:			Date and Time:				
Nom:	Prashant 2000-10-10		Agreed healthcare network:				
Carte ID:							
Full Name (first, middle, last):	Prashant 2000-10-10						
Age:	23.3		Prescribing Doctor / orientation: we fwef wef				
Marital Status :							
Gender :	Male						
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: Prashal Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Male edical Procedures: Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 2000-10-10 Carte ID: Full Name (first, middle, last): Age: 23.3 Marital Status: Gender: Male edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 2000-10-10 Agreed healthcar Carte ID: Full Name (first, middle, last): Age: Age: 23.3 Prescribing Doctowe fwef wef Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly D obligatoire		

<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 Referen Center	ice Medical			
Important: The validity of this form cannot exceed			exceed 5	d 5 days from the			Total amount:			
date of issue						To be paid by the patient			he patient	
Assignment code				To be paid by the insurance company			=			
5. Details Of Paramedical Procedures:							ıres:			
Dat	Date Code Designation (Medical acts)			Coefficient		Rate	Total Cost			
<u>Important:</u> The validity of this form cannot exceed			exceed 5	5 days			Total amount:			
from the date of issue				To be	paic	d by the patient				
Assignment code					To be paid by the insurance company					
Patient signature Signature and stamp medical Hea					al Heal	Signature and stamp of the Doctor				
Prescribed (Section Reserved For The			6. Med The Prescr	dicines	Section Reserved For The Pharmacist					
No:	Drugs			D	osage	Quantity	Tota	otal Cost		
		dol eg l.p. tion prolo	. 200 mg, comprimé à ngée	10	0	10 100				
				To	otal an	nount:	t: 100.00			
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 (%)	20.00
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	80.00
Signature and stamp Prescribing Doctor		Signat	ture and stamp Pharmacist