Medical Care Form

Claim number:4f4f

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care		2. Patient	3. Infos Reference Medical Center			
Matricule:			Date and Time:			
Nom:			Agreed healthcare network:			
Carte ID:	22					
	Suyesh 15151 2023-09-02					
Age:	0.3		Prescribing Doctor / orientation:			
Marital Status :						
Gender :	Male					
4. Details Of Medical 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 :	Access To Health Care Matricule: Nom: Suyesh Carte ID: 22 Full Name (first, middle, last): Age: O.3 Marital Status: Gender: Male edical Procedures: Code 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: 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 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 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 Reference Medical Center			
<u>lmportan</u>	<u>t:</u> The validit	y of this form cannot e	exceed 5 days t	from the		Tota	al amount:	
date of is	sue				-	Γο be paid by t	he patient	
Assignment code				To be paid by th insurance compan				
			5. Det	ails Of Pa	ramo	edical Procedu	ıres:	
Date	Code	Code Designation (Medical acts)		Coefficient		Rate	Total Cost	
<u>lmportant:</u> The validity of this form cannot exceed			exceed 5 days			Total amount:		
from the	date of issue			To be	paid	by the patient		
Assignment code				To be pa	be paid by the insurance company			
Patient	signature Signature and stamp medical Heal			thcare ce	ntre	Signature and stamp of the Doctor		
Prescribed (Section Reserved For The			6. Med The Prescr	dicines ribing	Section Reserved For The Pharmacist			
No:	Dr	ugs	Dosage	QuantityT	otal	Cost		
1				4	840			
	•		Total am	ount: 4	840.0	00		
<u>l</u>	<u>mportant:</u> Tl	ne prescribing		1				

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 (%)	3194.40
		To be paid by MAADO	1645.60
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist