Medical Care Form

Claim number:545gt

1. Health Insurance System Information			Filling Instructions					
SAM code:			Write legibly					
SAM:			ID obligatoire					
Information & Access To Health Care			2. Patient Policy	3. Infos Reference Medical Center				
Primary	Matricule:			Date and Time:				
insured	Nom:			Agreed healthcare	e networ	k:		
	Carte ID:							
	Full Name (first, middle, last):							
Patient	Age:			Prescribing Doctor / orientation: g45g 45g 45g				
	Marital Status :							
	Gender :							
4. Details Of M	edical Procedures:							
Date	it one	Designa acts)	ition (Medical	Coefficient	Rate	Total Cost		

<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	

Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the insurance company 5. Details Of Paramedical Procedures: Date Code Designation (Medical acts) Coefficient Rate Total Cost Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the insurance company To be paid by the insurance company Signature and stamp of the	Information & Access To Health Care				2. Patient Policy		s Referend	ce Medical	
Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the insurance company 5. Details Of Paramedical Procedures: Date Code Designation (Medical acts) Coefficient Rate Total Cost Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the insurance company Signature and stamp of the									
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5. Details Of Paramedical Procedures: Date Code Designation (Medical acts) Coefficient Rate Total Cost Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient Assignment code To be paid by the insurance company Signature and stamp of the	date of issi			To be	To be paid by the patient				
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Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the insurance company Signature and stamp of the	Date Code Designation (Medical acts)			acts)	Coefficient Rate			Total Cost	
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Assignment code To be paid by the patient To be paid by the insurance company				xceed 5 days		Total	l amount:		
Assignment code company	from the date of issue				To be	paid by th	ie patient		
Signature and stamp of the	Assignment code				To be pa	•			
Patient signature Signature and stamp medical Healthcare centre Doctor	Patient signature Signature and stamp med			medical Heal	thcare cei	ntre i -		stamp of the	
Prescribed (Section Reserved For The Prescribing Doctor) 6. Medicines Section Reserve For The Pharmacist				The	Section Reserve			tion Reserved	
No: Drugs Dosage Quantity Total Cost	No:	Dru	ıgs	Dosage	QuantityT	otal Cost			
1 1 1 1	1	ttt		1 1	1				
Total amount: 1.00 Important: The prescribing				Total am	ount: 1	unt: 1.00			

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 (%)	0.40	
		To be paid by MAADO	0.60	
Signature and stamp Prescribing Doctor		Signature and stamp Pharmacist		