Medical Care Form

Claim number :wefwef

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:			Agreed healthcare network:		
Carte ID:	585667				
Full Name (first, middle, last):	Ram Alliance 2003-08-22				
Age:	20.3		Prescribing Doctor / orientation:		
Marital Status :					
Gender :	Female				
edical Procedures:					
LOGE	Designation (Medical acts)		Coefficient	IRate	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: Ram All Carte ID: 585667 Full Name (first, middle, last): Age: 20.3 Marital Status : Gender : Female edical Procedures: Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Ram Alliance 2003-08-22 Carte ID: 585667 Full Name (first, middle, last): Age: 20.3 Marital Status: Gender: Female Edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Ram Alliance 2003-08-22 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: 20.3 Prescribing Docto Marital Status: Gender: Female Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Ram Alliance 2003-08-22 Carte ID: Full Name (first, middle, last): Age: Age: 20.3 Prescribing Doctor / orient Marital Status: Gender: Female Pesignation (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. Pati Policy		3. Infos Refere Center	3. Infos Reference Medical Center	
Important: The validity of this form cannot exceed			exceed 5 days	from the	Tot	al amount:
date of iss	sue				To be paid by	the patient
Assignmeı	Assignment code			To be paid by the insurance compa		-
			5. Det	ails Of Paı	ramedical Proced	ures:
Date	ate Code Designation (Medical acts)		acts)	Coefficien	nt Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed			exceed 5 days		Total amount	::
from the o	date of iss	sue		To be p	oaid by the patien	t
Assignment code				To be paid by the insurance company		
Patient	Patient signature Signature and stamp medical Healthcare centre Doctor			d stamp of the		
6. Medicines Prescribed (Section Reserved For The Prescribing Doctor)				ection Reserved t		
No:		Drugs	Dosage(QuantityTo	otal Cost	
1				40	0	
<u>lr</u>	Important: The prescribing		Total am	ount: 40	0.00	

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 (%)	26.40
		To be paid by MAADO	13.60
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist