Medical Care Form

Claim number: 32866

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:			
sured Nom: Dhiraj G. 2000-06-18		Agreed healthcare network:				
Carte ID:	5677777					
Full Name (first, middle, last):	Dhiraj G. 2000-06-18					
Age:	23.4		Prescribing Doctor / orientation: dfgdg dfdf sfd			
Marital Status :						
Gender :	Male					
edical Procedures:						
l ode	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: Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male Male Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Carte ID: 5677777 Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: 23.4 Prescribing Doctodfgdg dfdf sfd Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Full Name (first, middle, last): Age: Age: 2. Patient Policy Agreed healthcare networ Agreed healthcare networ Prescribing Doctor / orient dfgdg dfdf sfd Marital Status: Gender: Male Designation (Medical Coefficient Rate	

<u>Important:</u> The validity of this form cannot exceed 5 days from the date of issue		Total amount:	
		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 Referer Center	nce Medical	
<u>lmporta</u>	nt: The val	idity of this form cannot e	exceed 5 days	from the	Tot	al amount:
date of i	ssue				To be paid by t	he patient
Assignment code				To be paid by the insurance company		
	5. Details Of Paramedical Procedures:				ures:	
Date	Code	Designation (Medical	Designation (Medical acts)		nt Rate	Total Cost
<u>Important:</u> The validity of this form cannot exceed 5 da		exceed 5 days		Total amount		
from the	date of is	sue		To be	paid by the patien	
Assignm	ent code			To be pa	id by the insurance company	
Patien	t signatur	re Signature and stamp	Signature and stamp medical Healthcare centre Doctor			d stamp of the
6. Medicines Prescribed (Section Reserved For The Prescribing Doctor)						
No: Drug	įs		Dosage	Quantity	Total Cost	
-	prazole sa ispersible	ındoz 10 mg, comprimé	34	54 2	24516	
	les e aut - · ·	ti The processible -	Total an	nount: 2	24516.00	
<u>Important:</u> 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 (%)	4903.20
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO	19612.80
Sig	nature and stamp Prescribing Doctor	Signat	cure and stamp Pharmacist