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:			
Primary insured Nom:		nt 1 2024-02-04	Agreed healthcare network:			
Carte ID:						
Full Name (first, middle, last):	prashant 1 2024-02-04					
Age:	0.0		Prescribing Doctor / orientation: dhiraj gurve			
Marital Status :						
Gender :	Male					
4. Details Of Medical 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: prashar Carte ID: Full Name (first, middle, last): Age: 0.0 Marital Status : Gender : Male edical Procedures: Code Designation	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Prashant 1 2024-02-04 Carte ID: Full Name (first, middle, last): Age: O.0 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: prashant 1 2024-02-04 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: 0.0 Prescribing Docto dhiraj gurve Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Prashant 1 2024-02-04 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: O.0 Marital Status: Gender: Male Designation (Medical Coefficient Rate	

<u>Important:</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		Infos Referen enter	ce Medical		
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 1	from the		Tota	al amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by th insurance compan				
			5. Det	ails Of Pa	ırame	edical Procedu	ıres:	
Date	Code	Designation (Medical acts)		Coefficie	nt	Rate Total Cost		
<u>Important:</u> The validity of this form cannot exceed 5			exceed 5 days			Total amount:		
from the o	date of issue			To be	paid	by the patient		
Assignment code				To be pa	oe paid by the insurance company			
Patient signature Signature and stamp medical Heal			Signature and stamp of the Doctor					
Prescribed (Section Reserved For The			dicines ribing	Section Reserved For The Pharmacist				
No:	Dr	ugs	Dosage(Quantity	otal (Cost		
1				1	145			
			Total am	ount: 1	145.00)		
Important: The prescribing			<u> </u>					

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 (%)	145.00
		To be paid by MAADO	0.00
Sigi	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist