Medical Care Form

Claim number :

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 insured	Matricule:		Date and Time:
	Nom:	Prashant 2024-03-01	Agreed healthcare network:
Patient	Carte ID:	7807	
	Full Name (first, middle, last):	Prashant 2024-03-01	
	Age:	0.0	Prescribing Doctor / orientation:
	Marital Status :		
	Gender :	Male	

4. Details Of Medical 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		Total amount:	
		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

Important: 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	

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	Total amount:	
	To be paid by the patient	
Assignment code	To be paid by the insurance company	

Patient signature	Signature and stamp medical Healthcare centre	Signature and stamp of the Doctor

Prescribed (Section Reserved For Doctor)	6. Medicines The Prescribing	Section Reserved For The Pharmacist

No:	Drugs	Dosage	Quantity	Total Cost
1				100

Important: The prescribing	Total amount:	100.00

practitioner will **Prescribed (Section Reserved For** indicate the duration of treatment for each **Doctor)** drug,	**6. Medicines** **The Prescribing**	**Section Reserved For The Pharmacist**
this form is valid only for one pharmacy and	To be paid by the patient (%)	20.00
its validity cannot exceed 72 hours after delivery	To be paid by MAADO	80.00
Signature and stamp Prescribing Doctor	Signature and stamp Pharmacist	