


# 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 1 2024-02-04	Agreed healthcare network:		
Patient	Carte ID:				
	Full Name (first, middle, last):	prashant 1 2024-02-04			
	Age:	0.0	Prescribing Doctor / orientation: mentor Dental prashant		
	Marital Status :				
	Gender :	Male			
4. Details Of Medical Procedures:					
Date	Code	Designation (Medical acts)	Coefficient	Rate	Total Cost

<b>Important:</b> 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	
<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			
5. Details Of Paramedical Procedures:						
Date	Code	Designation (Medical acts)	Coefficient	Rate	Total Cost	
<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			
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	yyyyyyyyyy	1	10	120		
<u>Important:</u> The prescribing		Total amount:		120.00		

<p>practitioner will</p> <p><b>Prescribed (Section Reserved For</b></p> <p>indicate the duration of treatment for</p> <p>each</p> <p><b>Doctor)</b></p> <p>drug,</p>	<p><b>6. Medicines</b></p> <p><b>The</b></p> <p><b>Prescribing</b></p>	<p><b>Section Reserved</b></p> <p><b>For The Pharmacist</b></p>
<p>this form is valid only for one pharmacy</p> <p>and</p> <p>its</p> <p>validity cannot exceed 72 hours after</p> <p>delivery</p>	<p>To be paid by</p> <p>the patient (%)</p>	<p>120.00</p>
	<p>To be paid by</p> <p>MAADO</p>	<p>0.00</p>
<p>Signature and stamp Prescribing Doctor</p>	<div></div> <p>Signature and stamp Pharmacist</p>	