Medical Care Form

Claim number:333

1. Health Insurance System Information			Filling Instructions				
SAM code:			Write legibly				
		ID obligatoire					
Access To Health Care			3. Infos Reference Medical Center				
Matricule:			Date and Time:				
Nom:			Agreed healthcare network:				
Carte ID:	444						
	Eric dw	ed 2023-06-20					
Age:	0.3		Prescribing Doctor / orientation: wef wef wef				
Marital Status :							
Gender :	Male						
4. Details Of Medical 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: Eric dwo Carte ID: 444 Full Name (first, middle, last): Age: 0.3 Marital Status : Gender : Male edical Procedures: Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Eric dwed 2023-06-20 Carte ID: 444 Full Name (first, middle, last): Age: 0.3 Marital Status: Gender: Male edical Procedures: Code Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Eric dwed 2023-06-20 Agreed healthcare Carte ID: 444 Full Name (first, middle, last): Age: 0.3 Prescribing Doctowef wef wef wef Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Eric dwed 2023-06-20 Agreed healthcare networ Carte ID: 444 Full Name (first, middle, last): Age: O.3 Prescribing Doctor / orientwef wef wef 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. Patient Policy			Infos Referen enter	ce Medical		
Important: The validity of this form cannot exceed			exceed 5 days f	from the		Tota	al amount:		
date of issue				7	To be paid by the patient				
Assignment code						To be paid by the insurance company			
				5. Det	ails Of Par	ame	edical Procedu	ıres:	
Date	Code		Designation (Medical a	acts)	Coefficien	t	Rate	Total Cost	
<u>Important:</u> The validity of this form cannot e			xceed 5 days			Total amount:			
from the date of issue			To be paid by the patient						
Assignment code				To be paid by the insurance company					
Patient signature Signature and stamp r			medical Heal	edical Healthcare centre Doctor			l stamp of t	he	
6. Medicines Prescribed (Section Reserved For									

	escribed (Section Reserved For	The	dicines ribing	Section Reserved For The Pharmacist
No:	Drugs	Dosage	Quantity	Total Cost
	tramadol eg l.p. 200 mg, comprimé à libération prolongée	12	12	1452

Prescribed (Section Reserved For Doctor)			dicines ribing	Section Reserved For The Pharmacist	
2	solian 100 mg, comprimé sécable	22	22	26664	
	Important: The prescribing practitioner will indicate the duration of treatment for	Total amount:		28116.00	
each and	drug, this form is valid only for one pharmacy	To be paid by the patient (%)		27553.68	
	its validity cannot exceed 72 hours after delivery	To be paid by MAADO		562.32	
Signature and stamp Prescribing Doctor			Signature and stamp Pharmacist		