## **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 Center Policy		e Medica	al	
Matricule:			Date and Time:			
mary sured Nom: Prashant 2000-10-10		nt 2000-10-10	Agreed healthcare network:			
Carte ID:						
Full Name (first, middle, last):	Prashant 2000-10-10					
Age:	23.3		Prescribing Doctor / orientation: Otis MillBurn			
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: 23.3  Marital Status:  Gender: Male  edical Procedures:  Code  Designa	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom: Prashant 2000-10-10  Carte ID: Full Name (first, middle, last): Age: 23.3  Marital Status: Gender: Male  edical Procedures:  Designation (Medical	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Prashant 2000-10-10  Agreed healthcare  Full Name (first, middle, last):  Age:  Age:  23.3  Prescribing Docto Otis MillBurn  Marital Status:  Gender:  Male  Designation (Medical Coefficient	Write legibly  ID obligatoire  2. Patient Policy  Matricule:  Nom:  Prashant 2000-10-10  Agreed healthcare networ  Carte ID:  Full Name (first, middle, last):  Age:  Age:  23.3  Prescribing Doctor / orien Otis MillBurn  Marital Status:  Gender:  Male  Designation (Medical Coefficient Rate	

<u>lmportant:</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		nfos Referen Iter	ce Medical	
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 1	from the		Tota	il amount:
date of iss	sue				То	be paid by tl	ne patient
Assignment code				To be paid by the insurance company			
			5. Det	ails Of Pa	ramed	lical Procedu	res:
Date	Code	de Designation (Medical acts)		Coefficie	nt R	Rate Total Cost	
Important: The validity of this form cannot exceed			exceed 5 days		To	otal amount:	
from the o	date of issue			To be	paid by	y the patient	
Assignment code				To be pa	e 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		
No:	Dr	ugs	Dosage(	QuantityT	otal Co	ost	
1		processor		8	00		
			Total am	ount: 8	00.00		
Important: The prescribing			<u> </u>				

Prescrib 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 (%)	160.00
		To be paid by MAADO	346.00
Sigr	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist