Medical Care Form

Claim number :wef

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	Matricule:			Date and Time:			
insured	Nom:			Agreed healthcard	e networ	·k:	
Patient	Carte ID:						
	Full Name (first, middle, last):						
	Age:			Prescribing Doctor / orientation: sdf sdf ssdf			
	Marital Status :						
	Gender :						
4. Details Of M	edical Procedures:						
Date	Code	Designa acts)	ation (Medical	Coefficient	IRate	Total Cost	

<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	

Important: The validity of this form cannot exceed 5 days from the date of issue Assignment code Patient signature Signature and stamp medical Healthcare centre To be paid by the patient To be paid by the insurance company Signature and stamp of the Doctor For The Pharmacist Doctor Drugs Dosage Quantity Total Cost 1 3333 10 10 10 100 Total amount: 100.00	Information & Access To Health Care				2. Patient Policy		. Infos Referen Center	ce Medical	
Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient									
Assignment code To be paid by the insurance company	<u>Important</u>	exceed 5 days	from the		Tota	al amount:			
Some company Some	date of iss	sue					To be paid by the patient		
Date Code Designation (Medical acts) Coefficient Rate Total Cost Coefficient Rate Total Cost	Assignmei	nt code							
Important: The validity of this form cannot exceed 5 days from the date of issue Assignment code Patient signature Signature and stamp medical Healthcare centre To be paid by the patient To be paid by the insurance company Signature and stamp of the Doctor For The Pharmacist Doctor Drugs Dosage Quantity Total Cost 1 3333 10 10 10 100 Total amount: 100.00				5. Det	ails Of P	aram	edical Procedu	ıres:	
Important: The validity of this form cannot exceed 5 days from the date of issue To be paid by the patient To be paid by the insurance company Patient signature Signature and stamp medical Healthcare centre Prescribed (Section Reserved For The Prescribing Doctor) Section Reserved For The Pharmacist 1 3333 10 10 10 100 Total amount: 100.00	Date	Date Code Designation (Medical acts)		acts)	Coefficie	Coefficient Rate		Total Cost	
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Patient signature Signature and stamp medical Healthcare centre Doctor Prescribed (Section Reserved For The Pharmacist Prescribing Doctor) Doctor D	from the o	date of issu	e		To be	e paic	l by the patient		
Prescribed (Section Reserved For Doctor) Section Reserved For The Pharmacist Doctor) Doctor Doctor Total amount: 100.00	Assignmeı	nt code			To be pa	· · · · ·			
Prescribed (Section Reserved For The Pharmacist No: Drugs Dosage Quantity Total Cost 1 3333 10 10 10 100 Total amount: 100.00	Patient signature Signature and stamp med			medical Heal	aitheare centre I			l stamp of the	
1 3333 10 10 100 Total amount: 100.00	Prescribed (Section Reserved For Doctor)			The	Section Reserve				
Total amount: 100.00	No:	Dr	ugs	Dosage	Quantity	Total	Cost		
	1 3333		10	10	100	00			
IMPORTANTI INO NYOCCYINING	<u>Important:</u> The prescribing			Total am	nount: 100.00				

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 (%)	20.00
		To be paid by MAADO	80.00
Signature and stamp Prescribing Doctor		Signa	ture and stamp Pharmacist