Medical Care Form

Claim number: 5446546

1. Health Insurance System Information		Filling Instructions				
SAM code:		Write legibly				
SAM:			ID obligatoire			
Information & Access To Health Care			3. Infos Reference Medical Center			
Matricule:	Dhiraj G. 2000-06-18		Date and Time:			
Nom:			Agreed healthcare network:			
Carte ID:						
	Dhiraj G. 2000-06-18					
Age:	23.4		Prescribing Doctor / orientation: Otis MillBurn			
Marital Status :						
Gender :	Male					
edical 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: Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male Male Code Designa	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Carte ID: Full Name (first, middle, last): Age: 23.4 Marital Status: Gender: Male edical Procedures: Designation (Medical	Write legibly ID obligatoire 2. Patient Policy Matricule: Nom: Dhiraj G. 2000-06-18 Agreed healthcare Carte ID: Full Name (first, middle, last): Age: Age: 23.4 Prescribing Docto Otis MillBurn Marital Status: Gender: Male Designation (Medical Coefficient	Write legibly ID obligatoire 2. Patient Policy Matricule: Date and Time: Nom: Dhiraj G. 2000-06-18 Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: 2. Patient Policy Date and Time: Agreed healthcare networ Carte ID: Full Name (first, middle, last): Age: Dhiraj G. 2000-06-18 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		fos Referen	ce Medical		
<u>Important</u>	:: The validit	ry of this form cannot e	exceed 5 days 1	from the		Tota	l amount:	
date of issue						To be paid by the patient		
Assignment code				To be paid by the insurance company				
			5. Det	ails Of Pa	ramedi	ical Procedu	res:	
Date	Code	Designation (Medical acts)		Coefficier	nt Ra	ate	Total Cost	
Important: The validity of this form cannot exceed		exceed 5 days		То	tal amount:			
from the o	date of issue			To be	paid by	the patient		
Assignment code				To be pa	aid by the insurance company			
Patient	Patient signature Signature and stamp medical Heal			thcare cei	Signature and stamp of the Doctor			
Prescribed (Section Reserved For The			dicines ribing	Section Reserved				
No:	Dr	ugs	Dosage	QuantityT	otal Co	st		
1		processor		0				
	•		Total am	ount: 0.00				
Important: The prescribing			-					

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 (%)	0.00
		To be paid by MAADO	0.00
Sign	nature and stamp Prescribing Doctor	Signa	ture and stamp Pharmacist