附件2：

 **医疗保障基金结算清单**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  清单流水号 定点医疗机构名称 定点医疗机构代码 医保结算等级 医保编号 病案号 申报时间 年 月 日

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| **一、基本信息**姓名 性别🞎 1.男 2.女 出生日期 年 月 日 年龄 岁 国籍 （年龄不足1周岁）年龄 天 民族 患者证件类别 患者证件号码 职业 现住址 省（区、市） 市 县 工作单位名称 工作单位地址 单位电话 邮编 联系人姓名 关系 地址 省（区、市） 市 县 电话 医保类型 特殊人员类型 参保地 新生儿入院类型 新生儿出生体重 克 新生儿入院体重 克 |
| **二、门诊慢特病诊疗信息** |
| 诊断科别 就诊日期  |
| 诊断名称 | 诊断代码 | 手术及操作名称 | 手术及操作代码 |
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| **三、住院诊疗信息** |
| 住院医疗类型🞎 1.住院 2.日间手术 |
| 入院途径🞎 1.急诊 2.门诊 3.其他医疗机构转入 9.其他 |
| 治疗类别🞎 1.西医 2.中医（2.1 中医 2.2民族医） 3.中西医 |
| 入院时间 年 月 日 时 入院科别 转科科别  |
| 出院时间 年 月 日 时 出院科别 实际住院 天 |
| 门（急）诊诊断（西医诊断） 疾病代码 门（急）诊诊断（中医诊断） 疾病代码  |
| 出院西医诊断 | 疾病代码 | 入院病情 | 出院中医诊断 | 疾病代码 | 入院病情 |
| 主要诊断： |  |  | 主病： |  |  |
| 其他诊断： |  |  | 主证： |  |  |
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| 诊断代码计数  |
| 手术及操作名称 | 手术及操作代码 | 手术及操作日期 | 麻醉方式\* | 术者医师姓名 | 术者医师代码 | 麻醉医师姓名 | 麻醉医师代码 |
| 主要： |  |  |  |  |  |  |  |
| 其他： |  |  |  |  |  |  |  |
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| 手术及操作代码计数  |
| 呼吸机使用时间\_\_\_\_\_\_天\_\_\_\_\_\_小时\_\_\_\_\_\_分钟 |
| 颅脑损伤患者昏迷时间：入院前 天 小时 分钟 入院后 天 小时 分钟 |
| 重症监护病房类型\*（CCU、NICU、EICU、SICU、PICU、RICU、其他） | 进重症监护室时间\*（\_年\_月\_日\_时\_分） | 出重症监护室时间\*（\_年\_月\_日\_时\_分） | 合计（小时）\* |
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| 输血品种 输血量 输血计量单位  |
| 特级护理天数\*\_\_\_\_ 一级护理天数\*\_\_\_\_ 二级护理天数\*\_\_\_\_ 三级护理天数\*\_\_\_\_ |
| 离院方式 🞎 1.医嘱离院 2. 医嘱转院，拟接收机构名称 拟接收机构代码 3.转社区、转卫生院机构，拟接收机构名称 拟接收机构代码 4.非医嘱离院 5.死亡 9.其他 |
| 是否有出院31天内再住院计划🞎 1.无 2.有，目的  |
| 主诊医师姓名\*  | 主诊医师代码\*  |

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| **四、医疗收费信息** |
| 业务流水号： 票据代码： 票据号码：  | 结算期间： 年 月 日— 年 月 日 |
| **项目名称** | 金额 | 甲类 | 乙类 | 自费 | 其他 |
| 床位费 |  |  |  |  |  |
| 诊察费 |  |  |  |  |  |
| 检查费 |  |  |  |  |  |
| 化验费 |  |  |  |  |  |
| 治疗费 |  |  |  |  |  |
| 手术费 |  |  |  |  |  |
| 护理费 |  |  |  |  |  |
| 卫生材料费 |  |  |  |  |  |
| 西药费 |  |  |  |  |  |
| 中药饮片费 |  |  |  |  |  |
| 中成药费 |  |  |  |  |  |
| 一般诊疗费 |  |  |  |  |  |
| 挂号费 |  |  |  |  |  |
| 其他费 |  |  |  |  |  |
| 金额合计 |  |  |  |  |  |

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| **基金支付** | **基金支付类型** | **金额** | **个人支付** | 个人自付 |  |
| 医保统筹基金支付 |  |
| 其他支付： |  | 个人自费 |  |
| 大病保险 |  |
| 医疗救助 |  | 个人账户支付 |  |
| 公务员医疗补助 |  |
| 大额补充 |  |
| 企业补充 |  | 个人现金支付 |  |
| …… |  |
| …… |  |
| 医保支付方式🞎 1.按项目 2.单病种 3.按病种分值 4.疾病诊断相关分组（DRG） 5.按床日 6.按人头…… |
| 医疗机构填报部门 医保机构 医疗机构填报人 医保机构经办人  |

**（注：“\*”代表选填数据项）** |