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| 附件2  淄博市医疗保障定点零售药店申请表   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 药店名称 |  | | | | | | | | | 药店地址 |  | | | | | | | | | 药店类别 | 连锁门店□    单体□ | | 营业场所面积 | | ㎡ | | | | | 法定代表人 |  | | 法定代表人  身份证号 | |  | | | | | 医保负责人 |  | | 医保负责人  联系电话 | |  | | | | | 统一社会信用代码 | |  | | 成立日期 | | |  | | | 药品经营许可证号 | |  | | 发证日期 | |  | | | | 单位社会保险登记证编码 | |  | | | | | | | | 本单位申请成为基本医疗保险定点零售药店，并对以下事项作出承诺：  1.所提供的资料真实完整。  2.签订服务协议前按要求完善医疗保险信息系统。      申请单位（盖章）：    法定代表人签字：    申 请 时 间： 年 月 日 | | | | | | | |  | |