附件4

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 淄博市基本医疗保险医疗康复备案表 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 姓 名 | | |  | | | | 性别 | | | |  | | | | | | 年龄 | | | |  | | | | 病案号 | | | | |  | | | | | | |
| 身份证号 | | |  |  |  |  | |  | |  | |  | |  | |  | | |  |  | |  | |  | |  |  | | | |  | |  | | |  |
| 疾病诊断 | | |  | | | | | | | | | | | | | | | ICD－10疾病分类编码 | | | | | | | | | | |  | | | | | | | |
| 医疗康复治疗的理由 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医疗康复治疗的起止时间 | | | 从 年 月 日至 年 月 日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 共计 天 | | | | |
| 申 请 的 康复项 目 |  | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | |  | |
|  | | | | | | | | 经治医生（签名）：  年 月 日 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 康复机构审核意见： | | | | | | | | | | | | | 医保经办机构意见： | | | | | | | | | | | | | | |  | | | | | | | | |
|  | | （盖章） | | | | | | | | | | | （盖章） | | | | | | | | | | | | | | |
| 年 月 日 | | | | | | | | | | | 经办人： | | | | | | | | | | 年 月 日 | | | | | | | | | | | | | |
| 填表须知： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1、一个疾病过程的康复治疗支付原则上不超过90天，脑瘫按该项目限定支付规定执行。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2、经治医生应在住院病历上详细记载康复诊疗的项目名称、康复次数、天数及疗效等情况，规范填写《淄博市基本医疗保险医疗康复记录表》，以备核查，对不符合规定发生的康复医疗费，医保基金将不予支付。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |