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   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **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 | | | | | |  | |  | | | | |  | | | | |  | | | | | |  | |  | | | | |  | | | | |  | | | | | |  | |  | | | | |  | | | | |  | | | | | |  | |  | | | | |  | | | | |  | | | | | |  | |  | | | | |  | | | | |  | | | | | |  | |  | | | | |  | | | | |  | | | | | | **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： | | | |  | | | |  | | |  |  | | |  | | |  | | | |  | | | |  | | |  |  | | |  | | |  | | | |  | | | |  | | |  |  | | |  | | |  | | | |  | | | |  | | |  |  | | |  | | |  | | | |  | | | |  | | |  |  | | |  | | |  | | | |  | | | |  | | |  |  | | |  | | |  | | | |  | | | |  | | |  |  | | |  | | |  | | | |  | | | |  | | | 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： |  | | | |  |  | | |  |  | | |  | | |  | |  |  | | | |  |  | | |  |  | | |  | | |  | |  |  | | | |  |  | | |  |  | | |  | | |  | |  |  | | | |  |  | | |  |  | | |  | | |  | |  |  | | | |  |  | | |  |  | | |  | | |  | |  |  | | | |  |  | | |  |  | | |  | | |  | |  |  | | | |  |  | | |  |  | | |  | | |  | |  |  | | | |  |  | | |  |  | | |  | | |  | |  |  | | | |  |  | | |  |  | | |  | | |  | | 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）\* | | | |  | | |  | | | | |  | | | | | |  | | | |  | | |  | | | | |  | | | | | |  | | | |  | | |  | | | | |  | | | | | |  | | | | 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\* | | | | | | | | | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **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 |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **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）** |