转外就医证明

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| **姓 名** |  | | | | | **性 别** | | |  | | | | **出生日期** | | |  | | | | | | 第一联 经办单位留存 |
| **参保类别** | **职工医保 □ 居民医保 □** | | | | | | | | | | | | | | | | | | | | |
| **身份证号** |  |  |  |  |  | |  |  |  |  |  |  | |  |  | |  |  |  |  |  |
| **单位名称** |  | | | | | | | | **联系电话** | | | | |  | | | | | | | |
| **转出医院** |  | | | | | | | | **转入城市** | | | | |  | | | | | | | |
| **临床诊断** |  | | | | | | | | | | | | | | | | | | | | |
| **病情摘要** | **经治医生： 科室意见： 年 月 日** | | | | | | | | | | | | | | | | | | | | |
| **医**  **院**  **医**  **保**  **办**  **意**  **见** | **（医保办盖章）**  **经办人 ： 负责人： 年 月 日** | | | | | | | | | | | | | | | | | | | | |

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**注：转外手续当次有效；本次转外在90天内住院有效。**

转外就医证明

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| **姓 名** |  | | | | | **性 别** | | |  | | | | **出生日期** | | |  | | | | | | 第二联 参保人员留存 |
| **参保类别** | **职工医保 □ 居民医保 □** | | | | | | | | | | | | | | | | | | | | |
| **身份证号** |  |  |  |  |  | |  |  |  |  |  |  | |  |  | |  |  |  |  |  |
| **单位名称** |  | | | | | | | | **联系电话** | | | | |  | | | | | | | |
| **转出医院** |  | | | | | | | | **转入城市** | | | | |  | | | | | | | |
| **临床诊断** |  | | | | | | | | | | | | | | | | | | | | |
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| **医**  **院**  **医**  **保**  **办**  **意**  **见** | **（医保办盖章）**  **经办人 ： 负责人： 年 月 日** | | | | | | | | | | | | | | | | | | | | |

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**注：转外手续当次有效；本次转外在90天内住院有效。**