**重庆市基本医疗保险市级统筹特殊疾病申请表**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **姓名** |  | | **性别** |  | **年龄** |  |  | 照  片 |
| **身份证号** | | |  | | | |  |
| **电话号码** | | |  | | | |  |
| **申请特殊疾病病种** | | |  | | | | | |
| **本人选定就医医院** | | |  | | | | | |
| **病**  **情**  **介**  **绍** | | **申报人（或家属）签字：**  **年 月 日** | | | | | | |
| **单**  **位**  **意**  **见** | | **单位签字盖章：**  **年 月 日** | | | | | | |