附件6

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| XX区（县）医保电子处方定点医药机构接入申请汇总表 | | | | |
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| 填报单位:XXXX医保局（盖章） | | | | |
|
| 填报时间： 2023-10-XX | | 联络人/电话：姓名/电话号码 | | 分管领导/电话：姓名/电话号码 |
|
| 序号 | 医保区划代码 | 医保区划名称 | 定点医药机构名称 | 定点医药机构代码 |
| 1 | 必填 | 必填 | 必填 | 必填 |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
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