附件2

拟纳入基本医疗保险支付范围医用耗材推荐名单

推荐单位（加盖公章）：

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **序号** | **国家医用耗材代码** | **单件产品名称** | **一级分类 （学科、品类）** | **二级分类 （用途、品目）** | **三级分类 （部位、功能、品种）** | **医保通用名** | **具体功能及特征** | **采购价（元）** | **临床开始使用时间** | **年使用人次** | **年使用金额（万元）** | **批准文号/备案登记号** | **推荐医疗机构数量** | **备注** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

负责人： 填报人： 联系电话：