postalsaúde

GUIA TRATAMENTO ODONTOLÓGICO

2- Nº Guia no Prestador **12345678901234567890**

1 - Registro ANS	3 - Número da Guia Principal	4 - Data da Autorização	5 - Senha	6 - Data de Validade da Senha	7 - Número da Guia Atribuído pela Operadora
|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___| / |___|___| / |___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___| / |___|___| / |___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Dados do Beneficiário

8 - Número da Carteira	9 - Plano	10- Empresa	11 - Validade da Carteira	12 - Cartão Nacional de Saúde
|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|			|___|___| / |___|___| / |___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

13 - Nome	14 - Telefone	15 - Nome do titular do plano	16 -Atendimento a RN
	(|___|___|)|___|___|___|___|-|___|___|___|___|		|___|

Dados do Contratado Responsável pelo Tratamento

17 - Nome do Profissional Solicitante	18 - Número no CRO	19 - UF	20 - Código CBO
	| | | | | | | | | | | | | |	|___|___|	|___|___|___|___|___|___|

21 - Código na Operadora	22 - Nome do Contratado Executante	23 - Número no CRO	24 - UF	25 - Código CNES
|___|___|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|___|

26 - Nome do Profissional Executante	27 - Número no CRO	28 - UF	29 - Código CBO
	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|

Plano de Tratamento / Procedimentos Solicitados / Procedimentos Executados

	30-Tabela	31 - Código do Procedimento	32 - Descrição	33-Dente/Região	34-Face	35-Qtde	36-Qtde US	37-Valor R$	38-Franquia (R$)	39-Aut	40-Cod. Negativa	41-Data de Realização	42-Assinatura
01-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
02-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
03-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
04-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
05-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
06-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
07-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
08-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
09-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
10-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
11-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
12-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
13-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
14-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
15-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
16-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
17-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
18-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
19-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	
20-	|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|___|___|	|___|___|___|___|___|	|___|___|	|___|___|___|___|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___|___|___|	|___|___|/|___|___|/|___|___|___|___|	

43 - Data de Término do Tratamento	44 - Tipo de Atendimento	45 - Tipo de Faturamento	46 - Total Quantidade US	47 - Valor Total (R$)	48 – Valor Total Franquia (R$)
|___|___| / |___|___| / |___|___|___|___|	|___|	|____|	|___|___|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|___|___|,|___|___|

Declaro, que após ter sido devidamente esclarecido sobre os propósitos, riscos, custos e alternativas de tratamento, conforme acima apresentados, aceito e autorizo a execução do tratamento, comprometendo-me a cumprir as orientações do profissional assistente e arcar com os custos previstos em contrato. Declaro, ainda, que o(s) procedimento(s) descrito(s) acima, e por mim assinado(s), foi/foram realizado(s) com meu consentimento e de forma satisfatória. Autorizo a Operadora a pagar em meu nome e por minha conta, ao profissional contratado que assina esse documento, os valores referentes ao tratamento realizado, comprometendo-me a arcar com os custos conforme previsto em contrato.

49 – Observação / Justificativa

50–Data da Assinatura do Cirurgião-Dentista Solicitante	51–Assinatura do Cirurgião-Dentista Solicitante	52- Data da assinatura do Cirurgião-Dentista	53- Assinatura do Cirurgião-Dentista
|___|___| / |___|___| / |___|___|___|___|		|___|___| / |___|___| / |___|___|___|___|	

54-Data da assinatura do Beneficiário ou Responsável	55-Assinatura do Beneficiário ou Responsável	56– Data do carimbo da empresa
|___|___| / |___|___| / |___|___|___|___|		|___|___|/|___|___|/|___|___|___|___|