CERON Eletrobrás

GUIA TRATAMENTO ODONTOLÓGICO - COBRANÇA

2- Nº **000000080000**

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

Dados do Beneficiário

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

13 - Nome	14 - Telefone	15 - Nome do titular do plano
	(|___|___|)|___|___|___|___|-|___|___|___|___|	

Dados do Contratado Executante

16 - Código na Operadora / CNPJ / CPF	17 - Nome do Contratado	18 - Número no CRO	19 - UF	20 - Código CNES
|___|___|___|___|___|___|___|___|___|___|___|___|___|___|				

21 - Nome do Profissional Executante	22 - Número no CRO	23 - UF	24 - Código CBO S

Procedimentos Executados

25-Tabela	26 - Código do Procedimento	27 - Descrição	28-Dente/Região	29-Face	30-Qtd	31-Quantidade US	32-Valor	33-Franquia/Co-participação R$	34-Data Realização	35-Assinatura
1-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
2-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
3-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
4-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
5-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
6-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
7-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
8-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
9-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
10-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
11-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
12-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
13-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
14-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	
15-|___|___|	|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|	|___|___| / |___|___| / |___|___|	

36 - Data Previsão Término do Tratamento	37 - Tipo de Atendimento	38 - Tipo de Faturamento	39 - Total Quantidade US	40 - Valor Total R$	41 - Total Franquia / Co-participação R$
|___|___| / |___|___| / |___|___|	|____| 1 - Tratamento Odontológico 2 - Exame Radiológico 3 - Ortodontia 4 - Urgência/Emergência	|____| 1 - Total 2 - Parcial	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|	|___|___|___|___|___|___|,|___|___|

Declaro, que o tratamento descrito acima foi realizado 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

42 - Observação

43 - Data, local e Assinatura do Cirurgião-Dentista	44 - Data, local e Assinatura do Associado / Responsável	45-Data, local e Carimbo da Empresa
|___|___| / |___|___| / |___|___|	|___|___| / |___|___| / |___|___|	|___|___|/|___|___|/|___|___|