GUIA TRATAMENTO ODONTOLÓGICO

2- Nº **123456789012**

1 - Registro ANS	3 - Data de Emissão da Guia	4 - Data da Autorização	5-Senha	6 - Data Validade da Senha	7 - Numero Guia Principal
31684-9	|___|___| / |___|___| / |___|___|	|___|___| / |___|___| / |___|___|		|___|___| / |___|___| / |___|___|	

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 Responsável pelo Tratamento

16 - Nome do Profissional Solicitante	17 - Número no CRO	18 - UF	19 - Código CBO S

20 - Código na Operadora / CNPJ / CPF	21 - Nome do Contratado Executante	22 - Número no CRO	23 - UF	24 - Código CNES
|___|___|___|___|___|___|___|___|___|___|___|___|___|___|				

25 - Nome do Profissional Executante	26 - Número no CRO	27 - UF	28 - Código CBO S

Plano de Tratamento / Procedimentos Solicitados / Procedimentos Executados

	29-Tabela	30 - Código do Procedimento	31 - Descrição	32-Dente/Região	33-Face	34-Qtd	35-Quantidade US	36-Valor R$	37-Franquia/Co-participação R$	38-Aut	39-Data de Realização	40-Assinatura
1-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
2-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
3-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
4-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
5-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
6-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
7-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
8-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
9-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
10-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
11-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
12-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
13-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
14-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
15-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
16-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	
17-	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|		|___|___|	|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|___|___|	|___|	|___|___|/|___|___|/|___|___|	

41 - Data Término do Tratamento	42 - Tipo de Atendimento	43 - Tipo de Faturamento	44 - Total Quantidade US	45 - Valor Total R$	46 - Total Franquia / Co-participação R$
|___|___| / |___|___| / |___|___|	|____| 1 - Tratamento Odontológico 2 - Exame Radiológico 3 - Ortodontia 4 - Urgência/Emergência 5 - Auditoria	|____| T - Total P - Parcial	|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|	|___|___|___|___|___|___|___|___|___|___|___|

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.

47 - Observação

- Para realizar o planejamento, favor verificar as coberturas contratuais.
- Não pode ser cobrado do associado nenhuma diferença (R$) em relação ao procedimento solicitado.
- Atenção para o prazo de validade (3 meses).
- Em caso de endodontia, prótese fixa e exodontia anexar RX inicial e final na fatura.

48 - Data, local e Assinatura do Cirurgião-Dentista Solicitante	49- Data, local e Assinatura do Cirurgião-Dentista	50 - Data, local e Assinatura do Beneficiário / Responsável	51 - Data, local e Carimbo da Empresa
|___|___| / |___|___| / |___|___|	|___|___| / |___|___| / |___|___|	|___|___| / |___|___| / |___|___|	|___|___|/|___|___|/|___|___|