Attachment 2

Details of Dispute Mediation Case for Medical Expenditure of Insurance Contracted Medical Care Institution

Outpatient Inpatient Pre-Review					Date of receiving :						Acceptance No. :				
Name		ID No.			Cate	Category		erial o.		Y	T	л	Page		
Specialty		Origina of filing			pproval eup Filing	Origin filing	Y	Y/MN	1/DD	I	ſ	М	ge		
Illness (ICD code)								NHI							
	Order No.	(item/code		point]	Con	Comment		Payable Qty		Payable point.				
					-										
					-										
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					-										
Subtotal				point								_			
Total				point											
Code of medical care institution		Name of medical care institution			The application is filled in accordance with regulations set forth in National Health Insurance Dispute Mediation Regulations, with following item that are sufficient to be evidences: Copy of rechect									ems	
Address	s					notification document from Insurer, Copy of reply list, Copy of medical expenditure and physician order lists,									
By		Tel			Copy approval medical Examinat attachme	and history ion re	second , □X-ra eport, □	revie ny] Othe	w), [_pcs er] Re	elated	c	omp _pcs	lete	