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| **流动就业人员基本医疗保险批量转移申请表** | | | | | |
| 医保经办机构名称： | | | | | |
| 我单位 等 人需办理医疗保险转移事宜，名单附后： | | | | | |
| 序号 | 个人编号 | 姓名 | 身份证号码 | 转入地 （市、县/区） | 转出地 （市、县/区） |
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|  | 经办人： |  | 联系电话： |  |  |
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|  |  |  | 单位（盖章）： | |  |
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|  |  |  |  | 年 月 日 | |