



MODELLO DI PAGAMENTO: TASSE, IMPOSTE, SANZIONI E ALTRE ENTRATE

1. VERSAMENTO DIRETTO AL CONCESSIONARIO DI

2. DELEGA IRREVOCABILE A

AGENZIA/UFFICIO PROV.

PER L'ACCREDITO ALLA TESORERIA COMPETENTE

3. NUMERO DI RIFERIMENTO (*)

DATI ANAGRAFICI

4. COGNOME, DENOMINAZIONE O RAGIONE SOCIALE NOME DATA DI NASCITA

SESSO M o F COMUNE (o stato estero) DI NASCITA / SEDE SOCIALE PROV. CODICE FISCALE

giorno mese anno

5. COGNOME, DENOMINAZIONE O RAGIONE SOCIALE NOME DATA DI NASCITA

SESSO M o F COMUNE (o stato estero) DI NASCITA / SEDE SOCIALE PROV. CODICE FISCALE

giorno mese anno

DATI DEL VERSAMENTO

6. UFFICIO O ENTE

codice sub. codice (*)

7. COD. TERRITORIALE (*)

8. CONTENZIOSO

9. CAUSALE

10. ESTREMI DELL'ATTO O DEL DOCUMENTO

Anno Numero

11. CODICE TRIBUTO

12. DESCRIZIONE (*)

13. IMPORTO

14. COD. DESTINATARIO

PER UN IMPORTO COMPLESSIVO DI EURO

EURO (lettere)

ESTREMI DEL VERSAMENTO

(DA COMPILARE A CURA DEL CONCESSIONARIO, DELLA BANCA O DELLE POSTE)

DATA			CODICE CONCESSIONE/BANCA/POSTE	
giorno	mese	anno	AZIENDA	CAB/SPORTELLIO
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FIRMA

Autorizzo addebito sul conto corrente bancario

n. /

cod. ABI CAB

firma



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PROV.

PER L'ACCREDITO ALLA TESORERIA COMPETENTE

3. NUMERO DI RIFERIMENTO (*)

4.	COGNOME, DENOMINAZIONE O RAGIONE SOCIALE	NOME		DATA DI NASCITA
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6. UFFICIO O ENTE	7. COD. TERRITORIALE (*)	8. CONTENZIOSO	9. CAUSALE	10. ESTREMI DELL'ATTO O DEL DOCUMENTO
<div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 40px; height: 30px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 40px; height: 30px; background-color: #f0f0f0; margin-bottom: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> codice sub. codice (*) </div>	<div style="border: 1px solid black; width: 60px; height: 30px; background-color: #f0f0f0; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-bottom: 5px;"></div>		<div style="border: 1px solid black; width: 40px; height: 30px; margin-bottom: 5px;"></div>	<div style="display: flex; justify-content: space-between; font-size: x-small; margin-bottom: 5px;"> Anno Numero </div> <div style="border: 1px solid black; height: 30px; position: relative;"> <!-- Visual representation of the grid --> </div>

11. CODICE TRIBUTO

12. DESCRIZIONE (*)

13. IMPORTO

14. COD. DESTINATARIO

[illegible][illegible][illegible][illegible]

PER UN IMPORTO COMPLESSIVO DI EURO

EURO (lettere)

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(DA COMPILARE A CURA DEL CONCESSIONARIO, DELLA BANCA O DELLE POSTE)

DATA					CODICE CONCESSIONE/BANCA/POSTE	
					AZIENDA	CAB/SPORTELLO
giorno	mese	anno				



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	PROV.
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PER L'ACCREDITO ALLA TESORERIA COMPETENTE

3. NUMERO DI RIFERIMENTO (*)

4.	<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;">COGNOME, DENOMINAZIONE O RAGIONE SOCIALE</div> <div style="width: 25%;">NOME</div> <div style="width: 27%;">DATA DI NASCITA</div> </div> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>
	<div style="width: 15%;"> SESSO M o F <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> </div> <div style="width: 40%;"> COMUNE (o stato estero) DI NASCITA / SEDE SOCIALE <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> </div> <div style="width: 10%;"> PROV. <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> </div> <div style="width: 35%;"> CODICE FISCALE <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> </div>
	<div></div> <div>giorno</div> <div>me</div> <div>se</div> <div>anno</div>

5.	<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;">COGNOME, DENOMINAZIONE O RAGIONE SOCIALE</div> <div style="width: 25%;">NOME</div> <div style="width: 27%;">DATA DI NASCITA</div> </div> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>
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PER UN IMPORTO COMPLESSIVO DI EURO

EURO (lettere)

(DA COMPILARE A CURA DEL CONCESSIONARIO, DELLA BANCA O DELLE POSTE)

DATA						CODICE CONCESSIONE/BANCA/POSTE	
						AZIENDA	CAB/SPORTELLLO
giorno		mese		anno			

Date: _____	
Patient Name: _____	
Room No: _____	
Ref: _____	
Physician: _____	
Nurse: _____	
Pharmacist: _____	
Dietician: _____	
Social Worker: _____	
Occupational Therapist: _____	
Physical Therapist: _____	
Speech Therapist: _____	
Psychologist: _____	
Psychiatrist: _____	
Radiologist: _____	
Pathologist: _____	
Laboratory: _____	
Imaging: _____	
Surgery: _____	
Anesthesiology: _____	
Intensive Care: _____	
Neonatology: _____	
Pediatrics: _____	
Geriatrics: _____	
Oncology: _____	
Hematology: _____	
Nephrology: _____	
Endocrinology: _____	
Gastroenterology: _____	
Hepatology: _____	
Pulmonology: _____	
Cardiology: _____	
Neurology: _____	
Ophthalmology: _____	
Otorhinolaryngology: _____	
Dermatology: _____	
Plastic Surgery: _____	
Urology: _____	
Gynecology: _____	
Obstetrics: _____	
Pediatric Surgery: _____	
Neurosurgery: _____	
Orthopedics: _____	
Trauma: _____	
Burns: _____	
Transplantation: _____	
Reproductive Medicine: _____	
Infertility: _____	
Genetics: _____	
Molecular Biology: _____	
Biochemistry: _____	
Microbiology: _____	
Immunology: _____	
Allergy: _____	
Dentistry: _____	
Podiatry: _____	
Optometry: _____	
Audiology: _____	
Pharmacy: _____	
Nursing: _____	
Physiotherapy: _____	
Occupational Therapy: _____	
Speech Therapy: _____	
Psychology: _____	
Psychiatry: _____	
Radiation Oncology: _____	
Medical Oncology: _____	
Surgical Oncology: _____	
Hematology/Oncology: _____	
Nephrology/Oncology: _____	
Endocrinology/Oncology: _____	
Gastroenterology/Oncology: _____	
Pulmonology/Oncology: _____	
Cardiology/Oncology: _____	
Neurology/Oncology: _____	
Ophthalmology/Oncology: _____	
Otorhinolaryngology/Oncology: _____	
Dermatology/Oncology: _____	
Plastic Surgery/Oncology: _____	
Urology/Oncology: _____	
Gynecology/Oncology: _____	
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Reproductive Medicine/Oncology: _____	
Infertility/Oncology: _____	
Genetics/Oncology: _____	
Molecular Biology/Oncology: _____	
Biochemistry/Oncology: _____	
Microbiology/Oncology: _____	
Immunology/Oncology: _____	
Allergy/Oncology: _____	
Dentistry/Oncology: _____	
Podiatry/Oncology: _____	
Optometry/Oncology: _____	
Audiology/Oncology: _____	
Pharmacy/Oncology: _____	
Nursing/Oncology: _____	
Physiotherapy/Oncology: _____	
Occupational Therapy/Oncology: _____	
Speech Therapy/Oncology: _____	
Psychology/Oncology: _____	
Psychiatry/Oncology: _____	
Radiation Oncology/Oncology: _____	
Medical Oncology/Oncology: _____	
Surgical Oncology/Oncology: _____	
Hematology/Oncology: _____	
Nephrology/Oncology: _____	
Endocrinology/Oncology: _____	
Gastroenterology/Oncology: _____	
Pulmonology/Oncology: _____	
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