様式第１４号

自立支援医療（育成医療）交付台帳兼支給台帳

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| 受給者番号 | | | | | |  |  | |  | | |  | | |  | | |  | | |  | | 市町村名 | | | | | | | 藤　　里　　町 | | | | | | | | | | | |  | | | | | |
| 受診者 | ふりがな | | |  | | | | | | | | | 男  ・  女 | | | 生年  月日 | | | | | | 昭和  平成  令和 | | | 年月日 | | | | | 申  請  者 | | ふりがな | | |  | | | | | 続柄 | |  | | | 職業 | |  |
| 氏名 | | |  | | | | | | | | | 氏名 | | |  | | | | |
| 病名 | | |  | | | | | | | | | | | | 発病  年月日 | | | | | | 昭和  平成  令和 | | | 年月日 | | | | | 生年月日 | | |  | 年月日 | | | 住  所 | |  | | | | | | |
| 被保険者証の  記号・番号 | | | |  | | | | | | | 保険者の名称 | | | | | |  | | | | | | | | | | 指定自立支援  医療機関 | | | | 病院・診療所 | | | | | | 名称・所在地 | |  | | | | | | | | |
| 薬局 | | | | | | 名称・所在地 | |  | | | | | | | | |
| 申請  年月日 | | | 交付  年月日 | | | | | 受給者証有効期間 | | | | | | | | | | | | 入院 | | | | 通院 | | | | 通算日数 | | | | | 自己上限額 | | | | 重度かつ継続 | | | | | | | 備 考 | | | |
| 始期 | | | | | | 終期 | | | | | |
| ．　． | | | ．　． | | | | | ．　． | | | | | | ．　． | | | | | | 日 | | | | 回 　日間 | | | | 日 | | | | |  | | | | 該当 ・ 非該当 | | | | | | |  | | | |
| ．　． | | | ．　． | | | | | ．　． | | | | | | ．　． | | | | | | 日 | | | | 回 　日間 | | | | 日 | | | | |  | | | | 該当 ・ 非該当 | | | | | | |  | | | |
| 診療月 | 支払月 | 医療費 | | | | | | | | | | | | | | | | | | | | | | | | | | | その他 | | | | | | | | | 合計 | | | | | | | | | |
| 診療日数 | | | 医療費  ① | | | | | 保険負担額  ② | | | | | | | | | 患者負担額  ③ | | | | | | | 県負担額  ④ | | | 治療用装具費  ⑤ | | | | | 看護料及び移送費  ⑥ | | | | 医療費総額 | | | | | 患者負担額 | | | 県負担額 | |
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| 合計 | |  | | |  | | | | |  | | | | | | | | |  | | | | | | |  | | |  | | | | |  | | | |  | | | | |  | | |  | |