様式第1号

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| 国民健康保険療養費支給申請書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受付日　　　　年　　月　　日  決定日　　　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 保険者名 | | | | | | | |  | | | | | | | | | | | | | | |
| 保険者番号 | | |  |  | |  | | | |  | | |  | | |  | | | |  | | |  | | | 療養を受けた者の氏名 | | | 被保険者氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| 被保険者番号 | | |  |  | |  | | | |  | | |  | | |  | | | |  | | |  | | |
| 診療年月 | | | 年　　　　月 | | | | | | | | | | | | | | | | | | | | | | |
| 診療日数 | | |  |  | | | 日 | | | | | | | | | | | | | | | | | | | 生年月日 | | | | | 1.明治　2.大正　3.昭和　4.平成　年　月　日 | | | | | | | | | | | | | | | | | | | | | | |
| 制度 | | | 1.国保　2.退職　3.老人 | | | | | | | | | | | | | | | | | | | | | | | 性別 | | | | | 1.男　2.女 | | | | | | | | | | | | | | | | | | | | | | |
| 療養期間 | | | | | | | | | | | | | | | | | | | | | | | | | | 本人家族 | | | 1.本人入院　2.本人外来　3.6歳未満入院　4.6歳未満外来  5.家族入院　6.家族外来　7.高齢9割入院　8.高齢9割外来  9.高齢7割入院　0.高齢7割外来 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 年　　月　　日　から | | | | | | | | | | | | | | | | | | | | | | | | | |
| 年　　月　　日　まで | | | | | | | | | | | | | | | | | | | | | | | | | |
| 所得区分 | | 1.低所得Ⅰ　2.低所得Ⅱ　3.3月超 | | | | | | | | | | | | | | | | | | | | | | | |
| 種類 | | | 海外療養費区分 | | | | | | | | | | | | | | | | | 1 | | | | | | 第三者の有無 | | | | | | | 1.業務上　2.第三者行為である　3.その他 | | | | | | | | | | | | | | | | | | | | | | | |
| 1.診療費　2.補装具　3.柔整　4.あんま・マッサージ　5.はり・灸　7.移送　8.その他　9.標準負担額 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 傷病名 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医療機関コード | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療を受けた医療機関等の所在地 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療を受けた医療機関名又は施術師 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 支給申請をした理由 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 発病又は負傷の理由 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 療養に要した費用額 | | | | |  | | | |  | | |  | | |  | | |  | |  | |  | | |  | | 円 | 食事回数 | | | | | | | | | | |  | |  | | |  | |  | | | | | | | | | | |
| 審査認定額　※1 | | | | |  | | | |  | | |  | | |  | | |  | |  | |  | | |  | | 円 | 療養に要した費用額 | | | | | | | | | | |  | |  | | |  | |  | |  | |  | |  | |  | | 円 |
| 一部負担金 | | | | |  | | | |  | | |  | | |  | | |  | |  | |  | | |  | | 円 | 食事標準負担額 | | | | | | | | | | |  | |  | | |  | |  | |  | |  | |  | |  | | 円 |
| 支給金額 | | | | |  | | | |  | | |  | | |  | | |  | |  | |  | | |  | | 円 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ※金融機関の口座番号を左詰で記載してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 振込先 | 銀行  信用金庫  信用組合  農協 | | | | 本店  支店  出張所 | | | | | | | | | | | | | | | | | | | 1.普通  2.当座  9.その他 | | | | | | 口座番号 | | | | | |  |  |  | |  | | |  | |  |  |  | | | | | | | | |  |
| 口座名義人（カタカナ） | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| 上記のとおりに療養に要した費用に関する証拠書類を添えて申請します。  　　　　　　年　　月　　日  市町村長　様  申請者　　　　住所  氏名　　　　　　　　　　　　　　　　　　　　　　　㊞  連絡先 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |