Form A

Request to Attention physician 担当医へお願い

1．Please fill in this form so that the patient may claim the National Health insurance benefit.
国民健康保険の給付の申請に必要ですので、証明をお願いします。

2．This form should be completed and signed by the attending physician.
担当医が記入し、署名してください。

3．One form for each month and one for hospitalization / outpatient(home visit) should be filled out.
各月ごと、入院・入院外ごとに、1 枚ずつ必要です。

Attending Physician's Statement 診療内容明細書

1．Name of patient　　Age(Date of Birth)　　Sex (Male / Female)
患者名＿＿＿＿＿＿＿＿　年齢(生年月日)＿＿D/＿＿M/＿＿Y　性別（ 男 ・ 女 ）

2．Name of Illness or Injury preferably with the Number of International Classification of diseases for the use of National Health Insurance (See the attached paper)
傷病名及び国民健康保険用国際疾病分類番号（別紙参照）

＿＿＿＿＿＿＿＿　＿＿＿＿＿＿＿＿　＿＿＿＿＿＿＿＿

3．Date of First Diagnosis 初診日：　＿＿D/＿＿M/＿＿Y

4．Days of Diagnosis and Treatment 診療日数：　＿＿days

5．Type of Treatment 治療の分類

□ Hospitalization : From＿＿D/＿＿M/＿＿Y , to ＿＿D/＿＿M/＿＿Y
入院　自　至
（ ＿＿days / 日間 ）

□ Out patient or Home Visit：＿＿D/＿＿M/＿＿Y　＿＿D/＿＿M/＿＿Y
入院外　＿＿D/＿＿M/＿＿Y　＿＿D/＿＿M/＿＿Y

6．Nature and Condition of Illness or Injury (in brief) 症状の概要

7．Prescription, Operation and Any other treatments (on brief) 処方、手術その他の処置の概要

8．Was the treatment required as a result of an accidental injury?　Yes□　No□
治療は事故の傷害によるものですか。　はい　いいえ

9．Itemized Amounts paid to Hospital and /or Attending Physician：Fill in Form B
治療実費　様式 B に記入

10. Name of Attending Physician 担当医の名前

Name 名前：Last 姓 _____ First 名 _____ Title 称号 _____

Office 病院又は診療所：_____ Phone 電話：_____

Address 住所：_____

Date 日付：_____ D/ _____ M/ _____ Y Signature 署名：_____

Reference Number of your Medical Record (if applicable) 診療録の番号_____