Form A

Request to Attending 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.
(この様式は患者の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.(この様式は担当医が記入し、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.
(各月毎、入院・入院外毎に、この様式1 枚が必要です。)

Separate receipt required for prescriptions.(薬材料は別に処方箋を添付のこと。)

Attending Physician's Statement

診療内容明細書

1. Name of Patient (Last , First) Age (Date of Birth) Sex(Male・Female)
患者名_____ 年齢（生年月日）_____性別（男・女）_____

2. Name of Illness or Injury preferably with Number of International Classification of Diseases for the use National Health Insurance (See the other side of this form)
傷病名及び国民健康保険用国際疾病分類番号:_____

3. Date of First Diagnosis : D / M / Y _____/_____/_____
初診日 日 / 月 / 年 _____/_____/_____

4. Duration of Treatment :_____ days
診療日数 _____ 日

5. Type of Treatment
治療の分類
☐ Hospitalization : From_____/_____/_____ , to_____/_____/_____(_____days)
入院 自 _____/_____/_____ , 至_____/_____/_____(_____日間)
☐ Out patient or Home Visit :_____/_____/_____ , _____/_____/_____
入院外 _____/_____/_____ , _____/_____/_____

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

7. Prescription , Operation and Any other treatments (in 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 : Form B
治療実費 様式B

10. Name and Address of Attending Physician
担当医の名前及び住所
Name 名前 : Last 姓 _____ First 名 _____ Title 称号 _____
Address 住所 : Home 自宅 _____ phone 電話 _____
Office 病院又は診療所 _____ phone 電話 _____

Date 日付 :_____ Signature 署名_____
Attending Physician 担当医

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

Form B

Itemized receipt

領収明細書

(1) Fee for initial office visit	初診料	$
(2) Fee for follow-up office visit	再診料	$
(3) Fee for home visit	往診料	$
(4) Fee for hospital visit	入院管理料	$
(5) Hospitalization	入院費	$
(6) Consultation	診察費	$
(7) Operation	手術費	$
(8) X-ray examination	X線検査費	$
(9) Medication	医薬費	$
(10) Anesthetics	麻酔費	$
(11) Operating room charge	手術室費用	$
(12) Others (specify)	その他(項目明記)	$ $ $ $
(13) Total	合 計	$

Important : Exclude the amount irrelevant to the treatment, I-e, extra charge for a bed.
注　　意：高級室料等治療に直接関係ないものは除いて下さい。

Name and Address of Attending Physician／Superintendent of Hospital or Clinic
担当医又は病院事務長の名前及び住所

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

Address　：Home 自宅 _____ Phone 電話 _____
住所　　Office 病院又は診療所 _____ Phone 電話 _____

Date　：_____ Signature _____
日付　　署名