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| 後期高齢者医療　療養費支給申請書  　受付日　令和　 　年　 　月　 　日  決定日　令和　 　年　　 月　 　日   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 保険者番号 | 3 | 9 | 2 | 3 | 2 | 1 | 5 | 2 | 個人番号 | |  | |  |  |  |  | |  | |  |  |  |  |  |  | | 被保険者番号 |  |  |  |  |  |  |  |  | | 被保険者  氏名 | |  | | | | | | | | | | | | | | | | 公費負担者番号 |  |  |  |  |  |  |  |  | | 公費受給者番号 |  |  |  |  |  |  |  |  | 生年月日 | | 大正 ・ 昭和　　　 　　年　　 月　　 日 | | | | | | | | | | | | | | | | 診療年月 | 年　　　月 | | | | | | | | | 入外 | | 入院 ・ 外来 | | | | | 割合 | | ７割 ･ ８割 ・ ９割 | | | | | | | | | 診療日数 | 日 | | | | | | | | | 療養期間 | | 年　　月　　日 ～　　　年　　月　　日 | | | | | | | | | | | | | | |  |  |  | | --- | --- | | 種　　類 | 補装具 **・**  海外療養費 **・**  自費診療 **・**  移送費 | | 傷　病　名 |  | | 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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 療養（移送）に要した費用額 |  |  |  |  |  |  |  | 円 | 食事回数 |  |  |  |  |  |  | 回 | | 審査認定額 |  |  |  |  |  |  |  | 円 | 食事療養に要した費用額 |  |  |  |  |  |  | 円 | | 一部負担金額 |  |  |  |  |  |  |  | 円 | 食事標準負担額 |  |  |  |  |  |  | 円 | | 支給金額 |  |  |  |  |  |  |  | 円 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 該当するものに○をつけて下さい。該当するものがない場合は（）内に記載してください。網掛けの中は記載不要です。  口座名義人はカタカナで左詰めで記入してください。濁点・半濁点は１字として、姓と名の間は１字空けてください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 振込先 | 銀　　行  　　　　　　　　　　　　信用金庫  　　　　　　　　　　　農業協同組合  　　　　　　　　　　　（　　　　） | | | | | | | | 本　店・支　店  　　　　　　　　　（　　　　　） | | | | | | | | | | | | | | | 預金種別 | | 普 通  当 座  （　　　　） | | | | | | | |  | |  | |  | |  | |  | | |  | |  | | | 口座番号  左詰記載して下さい | |  |  |  |  |  |  |  | |  | | | | | | | | | | | | | | | | | | | | | | | 口座名義人  （カタカナ） | |  |  |  |  |  |  |  | |  | |  | |  | |  | |  |  | |  | |  | |  | |  |  |  |  | | **□**　**公金受取口座を利用します。（公金受取口座の利用は被保険者本人のみとなります。）**  ※　給付金等の受取口座として、国に事前に登録した公金受取口座を利用する場合は、「□　公金受取口座を利用します。」  にチェック（✔）してください。  ※　公金受取口座を利用する場合は、口座情報（上記太枠部）の記載や通帳の写しの添付等は不要です。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | --- | | 上記のとおり関係書類を添えて申請します。  　　令和　　 年 　　月 　　日  愛知県後期高齢者医療広域連合長　様  　　　　　　　　　　　　　〒　　　 　　－  　　　　申請者　　　住　　所    　　　　　　　　　　氏　　名　　　　　　　　　　　　　　　　　　　　　　　続柄  　　　　　　　　　　電話番号 |   被保険者以外が申請する場合および被保険者の口座以外の口座に振込みを希望される場合は以下の欄にも記入をして下さい。   |  | | --- | | **（委任欄）　代理人**　　（住所）  　　　　　　　　　　　（氏名）　　　　　　　　　　　　 　　（電話番号）  　　　　　　　　　　　（被保険者との関係）  　　　　私は上記の者を代理人と定め、次の権限を委任します。(該当するものの□にチェック(✔)してください。)  　　　　　　　□ この申請書における療養費等の申請に関すること。  　　　　　　 　□ この申請に基づく療養費等の受領に関すること。  **被保険者**　（住所）  　　　　　　　　　　　（氏名）　　　　　　　　　　　　　 　（電話番号） |   　　市区町村確認欄 　　　 　　 広域連合確認欄  **補装具の申請に必要な添付書類**  医師の証明書　領収書　装着証明書  **移送費の申請に必要な添付書類**  医師の意見書　移送に係る費用の領収書   |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 受付 |  | 入力 |  | 確認 |  |  | 確認 |  | 訂正 |  |   **海外療養費の申請に必要な添付書類　　　　　　　自費診療分の申請に必要な添付書類**  　　　 診療明細書（翻訳文を添付）　領収書明細書　　 診療報酬明細書　領収書  　 領収書　同意書　パスポート等の写し |