

Form A
様式 A

- This form is used for claiming the social insurance benefit.
この様式は社会保険の給付の申請に使用されます。
- This form should be completed and signed by the attending physician.
この様式は担当医が書き、かつ署名して下さい。
- No. 5 (TYPE OF TREATMENT) should be filled out monthly when hospitalization/outpatient (home visit) extends for two month period.
入院・入院外が次の月に亘る時は、下記の5. に月別に記入して下さい。

Attending Physician's Statement
診 察 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
傷病名 (日本語訳:)

3. Date of First Diagnosis : 19
初診日

4. Days of Diagnosis and Treatment : days
診察日数

5. Type of Treatment
治療の分類

Hospitalization : (days)
入院 (日間)

MARK THE DATE PATIENT RECEIVED TREATMENT																
MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	/
MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	/

Outpatient or Home Visit : (days)
入院外 (日間)

MARK THE DATE PATIENT RECEIVED TREATMENT																
MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	/
MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	/

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 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 accounts paid to Hospital and/or Attending Physician : Form B
治療費 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
Name of Hospital or Clinic (病院又は診療所名)
Address 住所

Date 日付 Signature

Attending Physician 担当医
Reference Number of your Medical Record (if applicable)
診療録の番号

Form B
様式 B

- This form should be completed and signed by the attending physician/superintendent of Hospital or Clinic.
この様式は担当医又は病院事務長が書き、かつ署名して下さい。
- This form should be filled out monthly when hospitalization/outpatient (home visit) extends for two month period.
入院・入院外が次の月に亘る時は月別に記入して下さい。

Itemized Receipt
領 収 明 細 書

	Payment (支払金額)			
	Outpatient or Home visit (入院外)		Hospitalization (入院)	
	Month() ()月分	Month() ()月分	Month() ()月分	Month() ()月分
(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) Professional Nursing 職業看護婦費				
(9) X-Ray Examinations X線検査費				
(10) Laboratory Tests 諸検査費				
(11) Medicines 医薬費				
(12) Surgical Dressing 包帯費				
(13) Anaesthetics 麻酔費				
(14) Operating Room Charge 手術室費用				
(15) The Others (Specify) その他(特記せよ)				
(16) Tax 税金				
(17) Total 合計				
Currency (unit) 通貨単位				

Important : Exclude the amount irrelevant to the treatment, i.e. payment for luxurious room charge.

注 意 : 高級室料等治療に直接関係の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 : Last First Title
名前 姓 名
Name of Hospital or Clinic (病院又は診療所名)
Address 住所

Date : Signature
日付 署名