Form A
様 式 A

1. 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。
2. 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。
3. One form for each month, one form for hospitalization／outpatient and home visit.
各月毎、入院・入院外毎に付この様式が１枚必要です。

# 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＿＿＿＿＿＿＿＿＿＿ 年令（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 of Social Insurance (See the other side of this form)
傷病名及び社会保険用国際疾病分類番号（裏面参照）
3. Date of First Diagnosis ： ＿＿＿＿＿＿, 20＿＿＿＿
初 診 日
4. Days of Diagnosis and Treatment： ＿＿＿＿＿＿ days
診療日数
5. Type of Treatment
治療の分類
☐ Hospitalization： From ＿＿＿＿＿＿ , 20＿＿＿＿ to ＿＿＿＿＿＿ 20＿＿＿＿（ days）
入 院 自 至 （ 日間）
☐ Out patient or Home Visit： ＿＿＿＿＿＿ , 20＿＿＿＿ ＿＿＿＿＿＿, 20＿＿＿＿
入 院 外 ＿＿＿＿＿＿ , 20＿＿＿＿ ＿＿＿＿＿＿, 20＿＿＿＿
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＿＿＿＿＿＿＿＿＿＿
Address 住所 ：Home 自宅＿＿＿＿＿＿＿＿＿＿ Phone＿＿＿＿＿＿＿＿＿＿
Office 病院又は診療所＿＿＿＿＿＿＿＿＿＿ Phone＿＿＿＿＿＿＿＿＿＿

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
様 式 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) | Professional Nursing | 職業看護師費 | $ | |
| (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) | Anesthetics | 麻酔費 | $ | |
| (14) | Operating Room Charge | 手術室費用 | $ | |
| (15) | The Others (Specify) | その他（特記せよ） | $ | $ |
| | | | $ | $ |
| (16) | Total | 合計 | $ | |

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

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

Date Signature
日付 署名