

Request to Attending Physician
担当医へのお願い

1. Please fill in this form so that the patient may claim the health insurance benefit.
この様式は、患者の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、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、この様式1枚が必要です。

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 of Social Insurance
(Please refer to the table attached). 傷病名及び健康保険用国際疾病分類番号

3. Date of First Diagnosis : 初診日 _____

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

5. Type of Treatment 治療の分類

| | | | | | |
|-----------------------------------------------------|------|-----------------------|----|-----------------------|----------------|
| <input type="checkbox"/> Hospitalization : | From | _____ / _____ / _____ | to | _____ / _____ / _____ | (_____ days) |
| 入院 | 自 | | 至 | | (_____ 日間) |
| <input type="checkbox"/> Outpatient 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
治療は事故の障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
医療機関、または担当医に支払った医療費の内訳:様式Bによる

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 _____