

TO BE COMPLETED BY PHYSICIAN (HEALTHCARE PROVIDER)

医師(療養担当者)記入用

Request to the Attending Physician
担当医へのお願い

- Please fill out this form so that the patient may claim health insurance benefits.
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。
- This form should be completed and signed by the attending physician.
この様式は担当医が記入し、かつ署名してください。
- One form for each month, and for each hospitalization / outpatient visit (home visit) should be filled out.
各月毎、また入院、入院外毎につき、この様式 1 枚が必要です。

Form A
様式 AAttending Physician's Statement
診療内容明細書

- Name of Patient (Last, First) Sex Male • Female
患者名 _____ 性別
Date of Birth (D / M / Y) Medical Record Number 診療録番号
生年月日 _____ . _____ . _____

- Name of Illness or Injury, Preferably with the International Classification of Diseases Number
For Health Insurance Purposes. (Please refer to the table attached to this form.)
傷病名及び健康保険用国際疾病分類番号 (No.)

- Date of Initial Visit (D / M / Y)
初診日 _____ . _____ . _____
- No. Days of Visit/Treatment
診療日数 _____ days
- Type of Treatment (D / M / Y)
治療の分類
☐ Hospitalization From _____ / _____ / _____ to _____ / _____ / _____ (_____ days)
入院 自 _____ / _____ / _____ 至 _____ / _____ / _____ (_____ 日間)
☐ Outpatient or Home Visit _____ / _____ / _____ . _____ / _____ / _____
入院外 _____ / _____ / _____ . _____ / _____ / _____
- Nature of Illness or Injury (in brief)
病状の概要

- Prescription, Operation and Any Other Treatments (in brief)
処方、手術その他の処置の概要

- Was treatment required as a result of accidental injury? _____ ☐ Yes ☐ No
治療は事故の傷害によるものですか？
- Breakdown of Medical Expenses Paid to Hospital and / or Attending Physician : Please fill out 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

ATTENDING PHYSICIAN INFORMATION 担当医情報欄

Medical Institution Name: (医療機関名)

Address: (住所)

Name of Physician: (担当医名)

Title: (称号)

Signature: (署名)

Phone: (電話)

Date Completed: (作成年月日)

2. 傷病名及び健康保険用国際疾病分類番号

7.処方、手術その他の処置の概要

電話