Form A

Attending Physician's Statement 診療内容明細書

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 social insurance benefit. この様式は社会保険の給付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書き、かつ署名してください。
- 3. One form for each month and one form for hospitalization / outpatient (home visit) should be filled out. 各月毎、入院・入院外毎につき、この様式1枚が必要です。

Form B

Itemized Receipt 領 収 明 細 書

Request to Attending Physician or Superintendent of Hospital / Clinic 担当医または病院事務長へのお願い

- 1. Please fill in this form so that the patient may claim the social insurance benefit. この検式は社会保険の給付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 either the attending physician or the superintendent of a hospital / clinic.
 - この様式は担当医または病院の事務長が書き、かつ署名してください。
- 3. One form for each month and one form for hospitalization / outpatient (home visit) should be filled out. 各月毎、入院・入院外毎につき、この様式1枚が必要です。
- 4. If not in dollars, please specify the unit used. ドル以外の貨幣の場合はその旨を書いてください。

Requests to the Attending Physician

担当医へのお願い

- 1. Please certify this form so the patient may claim National Health Insurance benefits in Japan. この様式は患者の国民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. Please write details of the patient's treatment. 診療内容については、詳細に記載してください。
- 3. This form should be completed and signed by the attending physician. この様式は担当医が書き、かつ署名してください。
- 4. One form is needed for each and every inpatient or outpatient treatment visit. 各月年, 入院, 入院外毎に付き, この様式1枚が必要です。

Form A (様式A)

Attending Physician's Statement 診療内容明細書

				> MILL 3-41 - 92.	1 3-4 1504				
1.	Patient Name (La	st. First)	Age (D	ate of Birth	in pare	ntheses)	Male	/ Female	:
	患者名			下船(生年月日			性别(
2.	Name of illness of	r injury. Pleas	se include "	Number of	Internat	ional Clas	sification	of Disea	ses
	for the Use of Nat	ional Health	Insurance"	(see separa	tely atta	ched form)		
	病症名及び国民健康	保険用国際疾	防分類番号(別紙参照)					
3.	Date of first diagr	osis D/M	I/Y	, '	1				
	初診日	日/)]/年	1	1				
4.	Duration of treatn	nent	days						
	診療日数		B						
5.	Type of treatment								
	治療の分類								
	☐ Hospitalization	ı: From	1	1	to	1	j	(days)
	入院	由	ſ	1	壬	1	Ţ	 (H)
	☐ Outpatient/Hor	me visit:	1	1	_	/	1		
	入院外		1	1		1	1		
6.	Brief summary of	illness or inj	ıry:		症状	の概要			
	Prescription(s). op						所その他のか コ NoE		
	この治療は事故の			t tar treezes			コーNOC いえ	-	
9.	For itemized amo 治療実費 様式	unts paid to h		⊬or attendin	g physic	cian: Form	В		•
10.	Name and address 担当医の名前及		physician:						
	Name 名前;	Last 姓		First	3		Title	称号	
	Address 住所;	Home 自宅	···			Pl	none No.	推話	
		Office 病院:	たは診療所			Pl	ione No.	電話	12.
	Date 目付		***************************************	Signature	署名 _				
					Atte	nding Phy	sician 担	当医	
		M	edical Reco	ord Ref. No.	(if app	licable) 診	療録の番	号	

Requests to the Attending Physician or Hospital/Clinic Manager 担当医または病院事務長へのお願い

- 1. Please certify this form so the patient may claim National Health Insurance benefits in Japan. この様式は患者の国民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 either the attending physician or hospital/clinic manager. この様式は担当医または病院の事務長が書き,かつ署名してください。
- 3. One form is needed for each and every inpatient or outpatient treatment visit. 各月毎,入院,入院外毎に付き,この様式1枚が必要です。
- 4. Please specify the monetary unit used. ドル以外の貨幣の場合はその旨を書いてください。

Date 目付

5. If patient was provided meals while hospitalized, please write no. of times and cost on the "Others" line

入院的	字に食事を扱	是供した場合は、回数と金額を	その他欄に記載してく	ださい。	cost on the Others line.
Form B		Ite	emized Receipt		
様式B			領収明細書		
(1)	First-tim	e Visit Fee	初診料		
(2)	Follow-	ıp Visit Fee	再診料		
(3)	Home V	isit Fee	往診料		
(4)	Hospital	Visit Fee	入院管理料		
(5)	Hospital	ization	入院費		
(6)	Examina	tion	診察費		
(7)	Operativ	e Treatment	手術費		
(8)	Professio	onal Nursing	職業看護婦費		
(9)	X-Ray E	xamination	X線検査費		
(10)	Laborato	ory Tests	諸検査費		
(11)	Medicati	ion	医薬費		
(12)	Surgical	Dressing	包带費		
(13)	Anesthet	tics	麻酔費		
(14)	Operatin	g Room Charge	手術室費用		
(15)	Others (I	Please Specify)	その他(項目明記)		
			例)食事代(回数) Ex.) Meals (x times)		
(16)	Total		승計		Monetary Unit is:
Importa 注意:	nt: Exclud 高級室料、	le amounts irrelevant to tre 書類発行料等治療に直接関係	eatment, such as Doc 系ないものは除いてくだ	ument Issuance Fees さい。	(貨幣単位) & Deluxe Room Charges.
		s of attending physician (記事務長の名前及び住所	or hospital/clinic ma	onager:	
Name	名前	Last 姓	· First 名	T	itle 称号
Address	;住所	Home 自宅		Phone No.	電話
		Office 病院または診療所	Phone No. 電話		

Signature 署名

Requests to the Dental Practition 歯科医へのお願い			G: 7 =	
1. Please certify this form so the patie この様式は患者の国民健康保険の 2. Please write details of the patient)給付の申請に必要です('s dental treatment.			
診療内容については、詳細に記載 3. This form should be completed an	d signed by the attending p	hysician.	e e	
この様式は担当医が記入し、署名 4. One form is needed for every 各月毎、入院・入院外毎にこの相 5. Please specify the monetary unit to ドル以外の貨幣の場合は、その旨	inpatient or outpatient 統式1枚が必要です。 sed.	treatment visit.		
	MIZED RECEIPT 領収明細書	(DENTAL) (歯科)		
Name of Patient (Last, First)	Age (Date of Bir	th in parentheses)) Sex	(Male /
患者名	年齢(生年月日)		性別(男	・女)
Date of First Diagnosis	communication by contracting the contracting t		n of Treatment 日数	day;
	Location of Teeth	(部位)		
Permanent Teeth (永久歯)			ry Teeth (乳菌	1)
A COLTAGO MONTO				
_ 8 7 6 5 4 3 2 1 1	1 2 3 4 5 6 7 8	VIV		
R 8 7 6 5 4 3 2 1 8 7 6 5 4 3 2 1 1 1. Condition 症病名			1	
	·missing tooth (F) &漏) ·extraction needs	(欠歯) ed (Z) (要抜歯)	·mouth sore (G) (I	
1. Condition 症病名 ·cavity (C) (虫歯)	·missing tooth (F) 長漏) ·extraction needs	(欠歯)	mouth sore (G) (I	口内炎) Fee
1. Condition 症病名	·missing tooth (F) 提漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	·mouth sore (G) (I	口内炎) Fee
1. Condition 症病名	·missing tooth (F) 提漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	mouth sore (G) (I	口内炎) Fee
1. Condition 症病名	·missing tooth (F) 提漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	mouth sore (G) (I	口内炎) Fee
1. Condition 症病名	·missing tooth (F) 提漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	mouth sore (G) (I	口内炎) Fee
1. Condition 症病名	·missing tooth (F) 提漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	mouth sore (G) (I	口内炎) Fee
1. Condition 症病名	·missing tooth (F) 提漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	mouth sore (G) (I	口内炎) Fee
1. Condition 症病名	·missing tooth (F) 提漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	mouth sore (G) (I	口内炎) Fee
1. Condition 症病名 *cavity (C) (虫歯) *pyorrhea alveolaris (P) (歯槽服 2.Dental Treatment 歯科治療 *First-time Visit Fee 初診料 *X-Ray Examination レントゲン杉 *Pulpectomy 抜髄 *Extraction 抜歯 *Filling 充填 *Inlay インレー *Metal Crown 金属冠 *Post Crown 継続歯	·missing tooth (F) 提漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	mouth sore (G) (I	口内炎) Fee
1. Condition 症病名	·missing tooth (F) 提漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	mouth sore (G) (I	口内炎) Fee
1. Condition 症病名	·missing footh (F) 漫漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	mouth sore (G) (I	口内炎) Fee
1. Condition 症病名	·missing footh (F) 漫漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	mouth sore (G) (I	口内炎) Fee
1. Condition 症病名	·missing footh (F) 漫漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	mouth sore (G) (I	口内炎) Fee
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1. Condition 症病名	·missing footh (F) 漫漏) ·extraction needs Location(s) of 患者	(欠歯) ed (Z) (要抜歯) Teeth Examined	mouth sore (G) (I	口内炎)

Name of Hospital or Clinic (病院または診療所名)

Phone No. 電話

Signature 署名

Address 住所

Date 日付