

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 national health insurance benefit.  
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 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

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  
National Health Insurance(See the other side of this form)  
病名及び国民健康保険用国際疾病分類番号(裏面参照)
3. Date of First Diagnosis;   D  /  M  /  Y        /      /  
初診日      日/月/年      /      /
4. Duration of Treatment; \_\_\_\_\_ days  
診療日数      日
5. Type of Treatment  
治療の分類  
 Hospitalization: From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ days)  
入院      自 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 至 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ 日)  
 Out patient 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 treatment(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   
この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; 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      Title 称号  
Address 住所;    Home 自宅      Phone 電話  
Office 病院または診療所      Phone 電話  
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 \_\_\_\_\_