

Form A
様式 A

- 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。
- 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。
- 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 Tarō Hakuō 年令(生年月日) 12/15 1963 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表章用国際疾病分類番号(裏面参照)

3. Date of First Diagnosis : 6/20, 20 03
初診日

4. Days of Diagnosis and Treatment: 1 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 : 6/20, 20 03, _____, 20____
入院外 _____, 20____, _____, 20____

6. Nature and Condition of Illness or Injury (in brief)
症状の概要
Allergic rash

7. Prescription, operation and any other treatments (in brief)
処方、手術その他の処置の概要
Celestone injection

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 Lowson First 名 Eddie
Address 住所 : Home 自宅 6- White Avenue NY 200 Phone (012) 345-6789
Office 病院又は診療所 5- White Avenue NY 120 Phone (012) 123-4567
Date 日付 6/25 / 99 Signature 署名 Eddie Lowson
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	\$	<u>35</u>	
(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	\$	<u>30</u>	
(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	\$	<u>65</u>	

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 Lowson First Eddie Title Doctor
名前 姓 名

Address : Home 自宅 6- White Avenue NY 200 Phone (012) 345-6789
住所 Office 病院又は診療所 5- White Avenue NY 120 Phone (012) 123-4567

Date 6/25 / 99 Signature Eddie Lowson
日付 署名