様式第4号（第7条関係）

こども・重度心身障害者・ひとり親家庭等医療費支給申請書

（償還払分）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 注　１　この申請書は、医療機関等で現金を支払った場合に使用するものです。  　　２　上段申請書欄は、申請者が記入してください。  　　３　中段診療報酬領収証明書欄は、医療機関等で記入してもらってください。なお、「保険給付が行われることを証明する書類」を添付するときは、記入の必要はありません。 | 受給者 | 公費負担者番号 | | | | | |  |  | | | |  | |  | |  | | | | |  | | | | |  | | | | |  | | 加入医療保険 | | 被保険者氏名 | | | | | | | | | | | | | | | | | | | | | |
| 公費負担医療の受給者番号 | | | | | |  |  | | | |  | |  | |  | | | | |  | | | | |  | | | | |  | | 記号・番号 | | | | | | | | | | | | | | | | | | | | | |
| 住所 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 名称 | | | | | | | | | | | | | | | | | | | | | |
| 氏名 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 附加給付の有無・内容　　有・無  (　　　　　　　　　　　　　) | | | | | | | | | | | | | | | | | | | | | |
| 生年月日  年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 医療機関等 | | 所在地 | | | | | | | | | | | | | | | | | | | | | |
| 申請額  (支払金額) | | | | | | 円 | | | | | | | | | | | | | | | | | | | | | | | | | | 名称(氏名) | | | | | | | | | | | | | | | | | | | | | |
| 振替先 | 金融機関名  店舗名 | | | | 銀行　　　　　　店 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 金融機関コード  店番 | | | | | | | | |  | |  | | |  | |  | | |  | |  | |  |
| 預金種別 | | | | 1　普通  2　当座 | | | | 口座番号 | | | | | | | |  | | |  | |  | | |  | |  | | |  | |  | 支払金額 | | | | | | | 千 | | 百 | | 十 | | | 万 | | 千 | | | 百 | | 十 | | 円 |
| 上記のとおり申請します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 年　　　月　　　日  申請者  　大崎上島町長様 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 住所  フリガナ  氏名 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療報酬領収証明書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏名 | | | | | | | | | | | | | | | 年　月診療分 | | | | | | | | | | | | | | | | | | | | | | | 入院　・　入院外 | | | | | | | | | | | | | | | | | | |
| 診療実日数　　　日 | | | | | | | | | | | | | | | | | | | | | | | 医科・歯科・調剤・その他 | | | | | | | | | | | | | | | | | | |
| 保険医療総医療費(総点数×10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 領収額 | | | | | | | | | | | | | | | | | | |
| 合計 | | | | | | | | | | | | | 百万 | | 十万 | | | 万 | | | | | 千 | | | | | 百 | | | | 十 | | 一 | | | 円 | 百万 | 十万 | | | | 万 | | 千 | | | 百 | | | 十 | | 一 | | 円 | |
| (再掲) | | 入院外1日目 | | | | | | | | | | |  | |  | | |  | | | | |  | | | | |  | | | |  | |  | | | 円 |  |  | | | |  | |  | | |  | | |  | |  | | 円 | |
| 入院外2日目 | | | | | | | | | | |  | |  | | |  | | | | |  | | | | |  | | | |  | |  | | | 円 |  |  | | | |  | |  | | |  | | |  | |  | | 円 | |
| 入院外3日目 | | | | | | | | | | |  | |  | | |  | | | | |  | | | | |  | | | |  | |  | | | 円 |  |  | | | |  | |  | | |  | | |  | |  | | 円 | |
| 入院外4日目 | | | | | | | | | | |  | |  | | |  | | | | |  | | | | |  | | | |  | |  | | | 円 |  |  | | | |  | |  | | |  | | |  | |  | | 円 | |
| 入院外5日目以降計 | | | | | | | | | | |  | |  | | |  | | | | |  | | | | |  | | | |  | |  | | | 円 |  |  | | | |  | |  | | |  | | |  | |  | | 円 | |
| 上記のとおり証明します。　　　　　　　　　　　　年　　　月　　　日  医療機関等　所在地  名称  氏名 　　　　　　　　　　　　　　㊞ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ここから下は記入しないでください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受付　　・　・ | | | | | |  | | | |  | | | | | | | | |  | | | | | | | | | | |  | | | | | |  | | | | | 支出命令  月　日 | | | | | | | | | 支給台帳  月　日 | | | | | | |
|  | | | |  | | | | | | | | |  | | | | | | | | | | |  | | | | | |  | | | | |
| 決裁　　・　・ | | | | | |
| 総医療費A | | | 保険給付額B | | | | | | | | 他公費負担額C | | | | | | | | | | | | | 一部負担金額D | | | | | | | | | | | | 支給決定額E  E＝A－(B＋C＋D) | | | | | | | | | | 負担区分 | | | | こ・障・ひ | | | | | | |
| 円 | | | 円 | | | | | | | | 円 | | | | | | | | | | | | | 円 | | | | | | | | | | | | 円 | | | | | | | | | |