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 health insurance benefit. 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。
- 2. 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。
- 3. One form for each month and one form for hospitalization/ outpatient (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。

Itemized Receipt 領収明細書

Form B

様式B

(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 ** Please fill in the content of the Laboratory Tests. **諸検査の内容を記入してください。	(1) Fee for Initial Office Visit	初		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 * **Please fill in the content of the Laboratory Tests.* *諸検査の内容を記入してください。 (11) Medicines** 医 薬 費 **Please fill in the name and the amount of the prescription of an individual medicine. ** ** ** ** ** ** ** ** ** ** ** ** **	(2) Fee for Follow-up Office Visit	再		診		料	\$:
(5) Hospitalization	-			診		料	\$
(5) Hospitalization	(4) Fee for Hospital Visit	入	院	管	理	料	\$
(6) Consultation 診察費	-	入		院		費	\$
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							通貨単位

Important: Exclude the amount irrelevant to the treatment. i. e, payment for a luxurious room charge. 注意: 特別室料等、治療に直接関係ないものは除いてください。

Name and Address of Attending Physician

担当医の名前及び住所

Name	Last(姓)	First(名)	Title(称号)
Address	Home(自宅)		Phone(電話)
	Office(病院または診療所)		Phone
Date(日付)	900	Signature(署名)	
			A

Attending Physician(担当医)

Reference Number of your Medical Record(if applicable)

診療録の番号

様式B 邦訳

(10)	諸検査費の内訳(諸検査の内容)								
(11)	医薬費の内訳(薬の名称、量)								
i									
(15)	特記事項								
	翻訳者								
	住所								
	氏名	(1)							
	電話								