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 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、この様式が１枚必要です。

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 of National Health Insurance (Please refer to the table attached to this form)
   傷病名及び国民健康保険用国際疾病分類番号 ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿(No.＿＿＿＿＿)
3. Date of First Diagnosis : D ／ M ／ Y ＿＿＿／＿＿＿／＿＿＿
   初診日
4. Duration of Treatment : ＿＿＿＿＿＿days
   診療日数
5. Type of Treatment
   治療の分類
   □Hospitalization : From＿＿＿／＿＿＿／＿＿＿, to＿＿＿／＿＿＿／＿＿＿(　days)
   入院　自＿＿＿／＿＿＿／＿＿＿ 至＿＿＿／＿＿＿／＿＿＿ (　日間)
   □Outpatient 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 treatments (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□
   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 : Last 姓＿＿＿＿＿＿＿＿ First 名＿＿＿＿＿＿＿＿ Title 称号＿＿＿＿＿＿＿＿
    名前
    Address : Home 自宅＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿ phone 電話＿＿＿＿＿＿＿＿
    住所 Office 病院又は診療所＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿ 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＿＿＿＿＿＿＿＿＿＿