　様式第２７号（第２４条関係）

自立支援医療受給者証（育成医療・更生医療）再交付申請書

　珠洲市福祉事務所長

　　次のとおり医療受給者証の再交付を申請します。

申請年月日　　　　年　　月　　日

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 受診者 | フリガナ |  | | | | | | | | | | | | | 性別 | | | | | | | 生年月日 | | | | | | | | | | | | |
| 氏名 |  | | | | | | | | | | | | | 男・女 | | | | | | | 年　　月　　日 | | | | | | | | | | | | |
| 個人番号 |  | |  | |  | | |  | | |  | | | |  | | |  | | | |  | | |  | | |  | |  | |  | |
| フリガナ |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所 | 電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保護者(受診者が18歳未満の場合記入) | | フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | 続柄 | | | | | | |
| 氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| 個人番号 | | | | |  | |  | |  | | |  | | | |  | | |  | | |  |  | |  | | |  | |  | |  |
| フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所 | | | | | 電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 自立支援医療費受給者番号 | |  |  | |  | | |  | |  | | |  | | | |  | | |  | |  | | | | | | | | | | | | |
| 医療受給者証の有効期間 | | 年　　月　　日　から　　　年　　月　　日　まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申請の理由 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

　　注　1　医療受給者証を破損又は汚損した場合の申請については、現在お持ちの医療受給者証を添付してください。

　　　　2　再交付を受けた後、失った医療受給者証を発見したときは、速やかに市に返還してください。