別記第２６号様式（第２１条、第２２条、第２４条関係）

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|  | | | | | | | | | | | | | | | | | | | | | | | 後期高齢者医療療養費支給申請書 | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受付日　　　　　　　　年　　　　月　　　　日  　　決定日　　　　　　　　年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 保険者番号 | | | 3 | | 9 | | | 1 | | 3 | | | 1 | | | 0 | | | 6 | | 5 | | | 個人番号 | | | | |  | |  | |  | | |  | |  | | | |  | | |  | | |  | |  | | | | |  | | |  |  | | |  | | | | |  | |  | | |  | | |  |  |
| 被保険者番号 | | |  | |  | | |  | |  | | |  | | |  | | |  | |  | | | 受けた  療養を | | | | | 被保険者氏名 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 公費負担者番号 | | |  | |  | | |  | |  | | |  | | |  | | |  | |  | | | 生年月日 | | | | | | | | | | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 公費受給者番号 | | |  | |  | | |  | |  | | |  | | |  | | |  | |  | | | 入外 | | | | | | | | | | | 入院・外来 | | | | | | | | | | | | | 割合 | | | | | | | | | | | | | ７・８・９割 | | | | | | | | | |
| 診療年月 | | | 年　　　月 | | | | | | | | | | | | | | | | | | | | | 療養期間 | | | | | | | | | 年　　　月　　　日　　　から | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療日数 | | |  | |  | | | 日 | | | | | | | | | | | | | | | | 年　　　月　　　日　　　まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 種類 | | | | | | ・補装具　・一般療養費（医科・歯科・調剤）　・その他（　　　　　　　　　　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 傷病名 | | | | | | 別添証明書のとおり | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療を受けた医療機関等の所在地 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療を受けた医療機関名又は施術師 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 支給申請をした理由 | | | | | | 1：治療上必要な装具を作成したため  　2：上記以外の理由を具体的に記入（　　　　　　　　　　　　　　　　　　　　　　　　　　　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 発病又は負傷の理由 | | | | | | 1：第三者行為（交通事故等）　2：その他（疾病等）  第三者氏名（　　　　　　　　　　）住所（　　　　　　　　　　　　　　　　　　　　　　　　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 療養に要した費用額 | | | | | | | | |  | |  | | |  | | |  | | |  | | | | | |  |  | | | 食事回数 | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |  | |  | | | | | | | | | | | | | | | | |
| 審査認定額　※　１ | | | | | | | | |  | |  | | |  | | |  | | |  | | | | | |  |  | | | 療養に要した費用額 | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |  | |  | | |  | | | | |  | | |  | | |  | |  |
| 一部負担金 | | | | | | | | |  | |  | | |  | | |  | | |  | | | | | |  |  | | | 食事標準負担額 | | | | | | | | | | | | | | | | | | |  | | | | |  | | | |  | |  | | |  | | | | |  | | |  | | |  | |
| 支給金額 | | | | | | | | |  | |  | | |  | | |  | | |  | | | | | |  |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 該当するものに○を付けてください。該当するものがない場合は（　）内に記載してください。網掛けの中は記載不要です。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 振込先 | | 銀行  信用金庫  信用組合  協同組合  （　　　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 本店・支店  （　　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | 預金種別 | | | | | 普通  当座  （　　　） | | | | | | | | | | | |  |
|  | | |  | | |  | | | | | |  | | |  | | | | |  | | | | |  | | |
| 口座番号等  左詰めで記載してください。 | | |  | | |  | | | | |  | | |  | | |  | | | | |  | |  | | |  | | | |  | | |  | | | |  | | | | |  | | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| 口座名義人  （カタカナ） | | |  | | |  | | | | |  | | |  | | |  | | | | |  | |  | | |  | | | |  | | |  | | | |  | | | | |  | | |  | | | | |  | | | | |  | | | |  | | | |  | | | | |  | | |  | | |
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| 口座名義人は、カタカナで上段から左詰めで記入してください。濁点・半濁点は１字として、姓と名の間は１字空けてください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 上記のとおりに療養に要した費用に関する証拠書類を添えて申請します。  　　　　 年　　 月　　 日  　　東京都後期高齢者医療広域連合長宛  申請者  住　所      氏　名    電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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