TO BE COMPLETED BY PHYSICIAN (HEALTHCARE PROVIDER)

医師(療養担当者)記入用

Request to the Attending Physician

担当医へのお願い

1. Please fill out this form so that the patient may claim health insurance benefits.
   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 for each hospitalization / outpatient visit (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。

Form A
様式 A

Attending Physician's Statement
診 療 内 容 明 細 書

1. Name of Patient (Last, First)
   患者名_____ Sex 性別 Male ・ Female

   Date of Birth (D / M / Y)
   生年月日_____ . _____ . _____ Medical Record Number 診療録番号 _____

2. Name of Illness or Injury, Preferably with the International Classification of Diseases Number For Health Insurance Purposes. (Please refer to the table attached to this form.)
   傷病名及び健康保険用国際疾病分類番号 (No.)

3. Date of Initial Visit (D / M / Y)
   初診日 _____ . _____ . _____

4. No. Days of Visit/Treatment
   診療日数 _____ days

5. Type of Treatment **治療の分類** (D / M / Y)

   ☐Hospitalization 入院 From / / to / / (days) **自 / / 至 / / (日間)**

   ☐Outpatient or Home Visit / / . / /

   入院外 / / . / /

6. Nature of Illness or Injury (in brief)
   病状の概要

7. Prescription, Operation and Any Other Treatments (in brief)
   処方、手術その他の処置の概要

8. Was treatment required as a result of accidental injury? ☐Yes ☐No
   治療は事故の傷害によるものですか？

9. Breakdown of Medical Expenses Paid to Hospital and / or Attending Physician : Please fill out Form B
   医療機関、または担当医に支払った医療費の内訳：様式 B による

ATTENDING PHYSICIAN INFORMATION 担当医情報欄

Medical Institution Name:(医療機関名)

Address:(住所)

Name of Physician:(担当医名) Title:(称号)

Signature:(署名) Phone:(電話)

Date Completed:(作成年月日) . .