Form A
様 式 A

Request to Attending Physician
担当医へのお願い

- This form is used for claiming the social insurance benefit.
  (この様式は社会保険の給付の申請にしようされます。)
- This form should be completed and signed by the attending physician.
  (この様式は担当医が書き、かつ署名して下さい。)
- One form for each month, one form for hospitalization / outpatient and home visit.
  (各月毎、入院・入院外毎につき、この様式 1 枚が必要です。)
- Separate receipt required for prescriptions (薬材料は別途、処方箋を添付のこと)

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 _____ (生年月日) ____／____／____ 性別 (男 ・ 女)

2. Name of Illness or Injury preferable with Number of International Classification of Diseases for the use of Social Insurance (Please refer to the table attached to this form)
傷病名及び社会保険表章用国際疾病分類番号 _____ No_____

3. Date of First Diagnosis : ____／____／____
初診日

4. Days of Diagnosis and 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 ☐
治療は事故の障害によるものですか? はい いいえ

9. Itemized amounts paid to Hospital and ／or Attending Physician : Fill in 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

10. Name and Address of Attending Physician
担当医の氏名及び住所

N a m e Last (姓) _____ First (名) _____

Address Home (自宅) _____ Phone (電話) _____

Office (病院又は診療所) _____ Phone (電話) _____

D a t e (日付) ____／____／____ Signature (署名) _____

Attending Physician (担当医)

Reference Number of your Medical Record (if applicable)
診療録の番号 _____