Form B
様 式 B

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。)

Itemized Receipt
(領収明細書)

1. Fee for Initial Office Visit	初　診　料	_____
2. Fee for Follow-up Office Visit	再診料	_____
3. Fee for Home Visit	往診料	_____
4. Fee for Hospital Visit	入院管理料	_____
5. Hospitalization	入院費	_____
6. Consultation	診察費	_____
7. Operation	手術費	_____
8. Professional Nursing	職業看護師費	_____
9. X-Ray Examinations	X 線検査費	_____
10. Laboratory Tests *	諸検査費*	_____
11. Medicines **	医薬費**	_____
12. Surgical Dressing	包帯費	_____
13. Anesthetics	麻酔費	_____
14. Operating Room Charge	手術室費用	_____
15. The Others (Specify)	その他(特記せよ)	
_____		_____
_____		_____
_____		_____
_____		_____
16. Total	合　　計	_____

***Please fill in the content of The Laboratory Tests.**
*諸検査の内容を記入してください。

****Please fill in the name and the amount of the prescription of an individual medicine.**
**処方した個々の薬の名称と量を記入してください。

Unit is (通貨単位)_____

Important: Exclude the amount irrelevant to the treatment. i. e, payment for a luxurious room charge.
注意: 特別室料等、治療に直接関係ないものは除いてください。

Name and Address of Attending Physician
担当医又の氏名及び住所

Ｎａｍｅ Last (姓)_____ First (名)_____

Address Home (自宅)_____ Phone (電話)_____

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_____