Form A

＊Please fill in this form so that the patient may claim the health insurance benefit.
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。
＊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。

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＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿ 年齢(生年月日)＿＿＿＿＿＿＿＿性別(男・女)＿＿＿＿＿＿＿＿

2. Name of Illness or Injury preferably with Number of International Classification of diseases for the use National Health Insurance (See the other side of this form)
   傷病名および国民健康保険用国際疾病分類番号(裏面参照)

3. Date of First Diagnosis 初診日　：　D(日)／M(月)／Y(年)　＿＿＿／＿＿＿／＿＿＿＿

4. Duration of Treatment 診療日数 ：　＿＿＿＿＿days(日)

5. Type of Treatment 治療の分類
   □Hospitalization 入院 ：From 自＿＿＿／＿＿＿／＿＿＿＿, to 至＿＿＿／＿＿＿／＿＿＿＿ (　　days (日間))
   □Out Patient or Home Visit 入院外 ：＿＿＿／＿＿＿／＿＿＿＿　＿＿＿／＿＿＿／＿＿＿＿
   ＿＿＿／＿＿＿／＿＿＿＿　＿＿＿／＿＿＿／＿＿＿＿

6. Nature and Condition of Illness or Injury (in details) 症状の概要(できるだけ詳細に)

7. Prescription, Operation and Any other treatments (in details) 処方，手術その他の処置の概要
   (できるだけ詳細に)

8. Was the treatment required as a result of an accidental injury?　Yes □　No □
   治療は事故の傷害によるものですか。　はい　いいえ

9. Itemized Amounts paid to Hospital and／or Attending Physician 治療実費 ：Form B　様式 B

10. Name and Address of Medical Institution and Attending Physician　医療機関・担当医の名前・住所

    Name of Medical Institution 医療機関名：

    ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

    Address of Medical Institution 医療機関の住所：

    Phone 電話

    ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

    Name of Attending Physician　担当医名：
    Last 姓　　First 名　　Title 称号

    ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

    Home Address of Attending Physician 担当医自宅の住所：

    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＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿