Form A

様式A

1. 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使用されます。

2. This form should be completed and signed by the attending physician.

この様式は担当医が書き、かつ署名してください。

3. One form for each month, one form for hospitalization / outpatient and home visit.

各月毎、入院・入院外毎に付この様式が1枚必要です。

Attending Physician's Statement 医科診療内容明細書

| 1. | Name of patient (Last, First) Age (Date 患者名 年齢(2 | | | | | | Sex (Male・Female) 性別(男・女) | | | |
|-----|---|-------------------------|-------------------|---------------|------|-------------|--------------------------------|--|--|--|
| 2. | | | | | | | | | | |
| ۷. | Social Insurance | | | | | | | | | |
| | 傷病名(社会保険表章) | 用国際疾病分類悉号) | | | | | | | | |
| 3. | Date of First Diagnosis: | | , 20 | | | | | | | |
| 0. | 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 | , 20 | to | , 20 | (| days) | | | |
| | 入院 | 自 | | 至 | | | | | | |
| | ☐ Out patient or Home V | visit: | , 20 | <u></u> | , 2 | 20 | | | | |
| | 入院外 | | , 20 | | , 2 | 20 | | | | |
| 6. | Nature and Condition of Ill 症状の概要 | ness or Injury (in bri | ef) | | | | | | | |
| 7. | Prescription, operation and 処方、手術その他の処態 | | s (in brief) | | | | | | | |
| 8. | Was the treatment required | d as a result of an acc | cidental injury ? | Yes \square | l N | lo 🗆 | | | | |
| | 治療は事故の傷害による | るものですか? | | はい | V | いえ | | | | |
| 9. | Itemized amounts paid to Hospital and / or Ateending physician : From B | | | | | | | | | |
| | 治療実費 | | | | | | | | | |
| 10. | Name and Address of Atter | nding Physician | | | | | | | | |
| | 担当医の名前及び住所 | | | | | | | | | |
| | Name 名前 : | Last 姓 | | First 名 | | | | | | |
| | Address 住所 : | Home 自宅 | | | Р | hone | | | | |
| | | Office 病院又は診療 | 所 | | Р | hone | | | | |
| | Date 目付 | Signatur | e 署名 | | | | | | | |
| | | | _ | | Ate | ending Phys | sician 担当医 | | | |

Reference Number of your Medical Record (if applicable)

診療録の番号

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 | 看護婦 | ·費 | \$ |
| (9) | X-Ray Examinations | X 線 | 検 査 | 費 | \$ |
| (10) | Laboratory Tests | 諸杉 | 查 | 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 | 也(特記 | せよ) | \$ \$ |
| | | | | | \$ \$ |
| (16) | Total | 合 | | 計 | \$ |

Important : Exclude the amount irrelevant to the treatment, i. e, payment for luxurious room charge.

注意 : 高級室料等治療に直接関係のないものは除いて下さい。

Name and Address of Attending Physician / Superintendent of Hospital or Clinic 担当医又は病院事務長の名前及び住所

| Name : | I | Las | t | First | | Title | |
|---------|---|-----|----------------|-------|-----------|-------|---|
| 名前 | | 姓 | | 名 | | | _ |
| Address | | : | Home 自宅 | | | Phone | |
| 住所 | | | Office 病院又は診療所 | | | Phone | _ |
| Dat | | 9 | | | Signature | | |
| 日 | 付 | | | | 署名 | | |