

- 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、かつ署名して下さい。

Form A
様式 A

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 _____ 年令(生年月日) _____ 性別(男・女)
2. Name of Illness or Injury (日本語訳: _____)
傷病名 _____
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 :

MARK THE DATE PATIENT RECEIVED TREATMENT																
MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

 (_____ days)
入院 _____ (_____ 日間)
- Outpatient or Home Visit :

MARK THE DATE PATIENT RECEIVED TREATMENT																
MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

 (_____ days)
入院外 _____ (_____ 日間)
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 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 : **Form B**
治療実費
- 10.Name and Address of Attending Physician
担当医の名前及び住所
Name 名前 : Last 姓 _____ First 名 _____
Name of Hospital or Clinic (病院又は診療所名) _____
Address 住所 _____
Phone _____
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 _____

This form should be completed and signed by the attending physician/
superintendent of Hospital or Clinic.

この様式は担当医又は病院事務長が書き、かつ署名して下さい。

Form B
様式 B

Itemized Receipt 領収明細書		Payment (支払金額)	
		Outpatient or Home visit (入院外)	Hospitalization (入院)
		Month() ()月分	Month() ()月分
(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	諸検査費		
(11) Medicines	医薬費		
(12) Surgical Dressing	包帯費		
(13) Anaesthetics	麻酔費		
(14) Operating Room Charge	手術室費用		
(15) The Others (Specify)	その他(特記せよ)		
(16) Tax	税金		
(17) Total	合計		
Currency (unit)		通貨単位	

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

注 意 : 室料等治療に直接関係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 : Last First Title
名前 姓 名
Name of Hospital or Clinic (病院又は診療所名)
Address 住所
Phone _____

Date : _____ Signature _____
日付 署名