

Request to Attending Physician

担当医へのお願い

1. 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。
2. 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。
3. One form for each month and one form for hospitalization/outpatient(home visit)should be filled out.
各月ごと、また入院・入院外ごとにつき、この様式1枚が必要です。

Attending Physician's Statement

診療内容明細書

Form A

様式A

1. Name of Patient (Last, First) 患者名	Age (Date of birth) 年齢(生年月日)	Sex (Male · Female) 性別(男・女)
2. Name of Illness or Injury preferably with the number of International Classification of Diseases for the use of Health Insurance. (Please refer to the table attached to this form.) 傷病名及び健康保険用国際疾病分類番号 _____ (No.)		
3. Date of first Diagnosis 初診日		
4. Days of Diagnosis and Treatment 診療日数		
5. Type of Treatment 治療の分類		
<input type="checkbox"/> Hospitalization 入院	From 自	/ / to / / (days) 至 (日間)
<input type="checkbox"/> 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? 治療は事故の傷害によるものですか。	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Itemized amounts paid to Hospital and/or Attending Physician 医療機関、または担当医に支払った医療費の内訳	: Fill in Form B : 様式Bによる	
10. Name and Address of Attending Physician 担当医の名前及び住所		
Name (名前) : Last (姓) Medical Institution Name (医療機関名) : Address(住所) : Date (日付) :	First (名) Title (称号) Phone : Signature (署名)	