Form A
様式 A

(This form must be completed by each institution for each month.)
(本用紙は一つの病院で1か月ごとに1枚を使用すること)

1 This form is used for claiming National Health Insurance benefit.
この様式は国民健康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 Two separate forms need to be completed for inpatient treatment and outpatient/home visit treatment, even when these are provided by the same institution. This also applies to medical treatment and dental treatment, for which two separate forms should be completed.
一つの病院でも入院と入院外は別に記入してください。また、医科と歯科も別に記入してください。

Attending Physician's Statement
診療内容明細書

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 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

☐ Inpatient
入院

☐ Outpatient or Home Visit
入院外

Mark the date patient received treatment																
Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
( )	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	／

(days)
(日数)

6 Nature and Condition of Illness or Injury (in brief)
症状の概要

_____

7 Prescription, operation and any other treatment (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 はい　　No いいえ

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

10 Name and Address of Attending Physician
担当医の名前及び住所

Name 名前 Family name 姓 _____ Given name 名 _____

Name of Hospital or Clinic (病院又は診療所名)

Address 住所 _____

Phone 電話 _____

Date 日付 _____

Signature 署名 _____

Reference Number of your Medical Record (if applicable) 診療録の番号 _____

* This form should be completed and submitted together with Form B (Itemized Receipt).
本様式は、「様式B」(領収明細書) とセットで使用してください。

Form B
様式 B

(This form must be completed by each institution for each month.)
(本用紙は一つの病院で１か月ごとに１枚を使用すること)

1 This form should be completed and signed by the attending physician /superintendent of the hospital or clinic.
この様式は担当医又は病院事務長が書き、かつ署名してください。

2 Two separate forms need to be completed for inpatient treatment and outpatient/home visit treatment, even when these are provided by the same institution. This also applies to medical treatment and dental treatment, for which two separate forms should be completed.
一つの病院でも入院と入院外は別に記入してください。また、医科と歯科も別に記入してください。

Itemized Receipt
領収明細書

		Payment (支払金額)
		Outpatient or Home Visit (入院外) Inpatient (入院)
		Month (月)〔 〕
(1) Fee for Initial Clinic Visit	初診料	
(2) Fee for Follow-up Clinic Visit	再診料	
(3) Fee for Home Visit	往診料	
(4) Fee for Inpatient Management	入院管理料	
(5) Hospitalization	入院費	
(6) Consultation	診察費	
(7) Operation	手術費	
(8) X-Ray Examinations	X線検査費	
(9) Laboratory Tests	諸検査費	
(10) Medicines	医薬費	
(11) Anesthetics	麻酔費	
(12) Operating Room Charge	手術室費	
(13) Other (Specify)	その他（特記）_____	
Other (Specify)	その他（特記）_____	
(14) Total	合 計	
Currency (unit)	通貨単位	

Note: Please exclude bedroom charge or any fee irrelevant to the treatment.
注意：入院したときの室料（差額ベッド代）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/Superintendent of Hospital or Clinic
担当医または病院事務室長の名前及び住所

Name 名前 Family name 姓 _____ Given name 名 _____ Title 称号 _____

Name of Hospital or Clinic 病院または診療所名 _____

Address 住所 _____

Phone 電話 _____

Date 日付 _____

Signature 署名 _____

*1 This form should be completed and submitted together with Form A (Attending Physician's Statement).
本様式は、「様式A」(診療内容明細書) とセットで使用してください。

2 The amount of benefit to be paid will be calculated based on the standard amount to be paid under the National Health Insurance program in Japan, as well as the details shown in Forms A and B, and therefore may be significantly lower than the actual amount paid at the institution.
給付額は、様式A、Bの内容を基に、国内での「国民健康保険」適用例により算定されますので、大きく下回ることがあります。