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 national health insurance benefit
   この様式は患者の国民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書き、かつ署名して下さい。
3. One form for each month and one form for hospitalization / outpatient (home visit) should be filled out. 各月毎、入院・入院外毎につき、この様式が必要です。

Form 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)傷病名及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 : D ／ M ／ Y ＿＿／＿＿／＿＿
   初診日 日 ／ 月 ／ 年 ＿＿／＿＿／＿＿

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

5. Type of Treatment
   治療の分類
   □Hospitalization : From＿＿／＿＿／＿＿, to＿＿／＿＿／＿＿(days)
   入院 自 ＿＿／＿＿／＿＿ 至＿＿／＿＿／＿＿(日間)
   □Out patient 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? Yes□ No□
   治療は事故の障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：様式 B

10. Name and Address of Attending Physician
    担当医の名前及び住所
    Name 名前 : Last 姓＿＿＿＿＿＿ First 名＿＿＿＿＿＿ Title 称 号＿＿＿＿＿＿
    Address 住所 : Home 自 宅＿＿＿＿＿＿＿＿＿＿＿＿ Phone 電 話＿＿＿＿＿＿
    : Office 病院又は診療所＿＿＿＿＿＿＿＿＿＿＿＿ 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＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿