

Form A

- 1, This form is used for claiming the health insurance benefit.
この様式は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、かつ署名して下さい。
- 3, One form for each month, one form for hospitalization/outpatient and home visit.
各月毎、入院・入院外毎に、この様式が1枚必要です。

Attending Physician's Statement 診療内容明細書

1, Name of patient (Last, First) (患者名) Sex (性別) Age (年齢) Date of Birth (生年月日)

Male ▪ Female

Month / Day / Year

2, Name of Illness or Injury preferably with Number of International Classification of Diseases for the use of National Health Insurance (See the Form D) (傷病名及び国民健康保険用国際疾病分類番号 (FormD参照))

No.

3, Date of First Diagnosis (初診日)

Month / Day / Year

4, No. Days of Visit / Treatment (診療日数)

Days

5, Type of Treatment (治療の分類)

☐ Hospitalization (入院)

From Month / Day / Year, to Month / Day / Year Days

☐ Out patient or Home Visit (入院外)

From Month / Day / Year, to Month / Day / Year Days

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

☐ No

9, Breakdown of Medical Expenses Paid to Hospital and / or Attending Physician : Please fill out Form B

(病院/主治医に支払われる医療費の内訳 : Form Bにご記入ください。)

ATTENDING PHYSICIAN INFORMATION (担当医情報欄)

Medical Institution Name (医療機関名)

Address (住所)

Phone (電話番号)

Name of Physician (担当医氏名)

Title (称号)

Medical Record Number (診療録番号) Date (記入日)

Signature (署名)

※ Attending Physician (担当医)