

# 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. この用紙は、患者の国民健康保険の給付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. この用紙は、担当医師が書き、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. この用紙は、毎月ごと、入院、入院外ごとに付き一枚必要です。

## 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 the Number of International Classification of diseases for the use of National Health Insurance (See the attached paper )  
傷病名及び国民健康保険用国際疾病分類番号 (別紙参照)
3. Date of First Diagnosis : \_\_\_\_\_ D / \_\_\_\_\_ M / \_\_\_\_\_ Y  
初診日 日 月 年
4. Days of Diagnosis and Treatment : \_\_\_\_\_ days  
診療日数 日間
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 : Fill in Form B.  
項目別治療実費 様式Bに記入
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 \_\_\_\_\_