第５号様式(第10条関係)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | 年　　月　診療分　障　医療助成費支給申請書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 診療年月 | 期間 | 入外別 | 保険対象  自己負担額 | | | | | | | 一部負担金  相当額 | | | | | | | 医　療　助　成　費 | | | | | | | 医療機関名 | 備　考 | | 負担限度額 | | | | | | | 付加給付額 | | | | | | | | 年　月 | 日～　日 | 入・外 |  |  |  |  |  |  | 円 |  |  |  |  |  |  | 円 |  |  |  |  |  |  | 円 |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | 年　月 | 日～　日 | 入・外 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | 年　月 | 日～　日 | 入・外 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | 年　月 | 日～　日 | 入・外 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | 年　月 | 日～　日 | 入・外 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | 年　月 | 日～　日 | 入・外 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | 年　月 | 日～　日 | 入・外 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | 合 計 | | 件 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| 負担者番号 | 8 | | 0 | | 1 | | | 3 | | |  | |  | | |  | |  | 被保険者氏名 | | |  | | | | | | | | | | | | | | |
| 受給者番号 | 9 | |  | |  | | |  | | |  | |  | | |  | |  | 被保険者記号番号 | | | | |  | | | | | | | | | | | | |
| 保険の種類 | １協会　２組合　３日雇  ４船員　５共済　６国保  ７後期高齢 | | | | | | | | | | | | | 保険者 | | | | | (名称) | |  | | | | | | | | | | | | | | | |
| 番号 | |  | |  | | |  | | |  |  | |  | |  | |  |
| 高齢受給者証の交付の有無 | １　有　　２　無 | | | | | | | | | | | | | 自己負担割合 | | | | | | | １　1割　　　２　2割　　　３　3割 | | | | | | | | | | | | | | | |
| 申請の種類 | １　医科　２　歯科　３　薬剤　４　補装具　５　施術　６　移送　７　その他 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申請の理由 |  | | | | | | | | | | | | | | | | | | 申　請　額 | |  | | | | | | | | | | | | | | | |
| 年　　月診療分の医療助成費の申請をします。  なお、支給額決定後は下記口座にお振込みください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 振込先  金融機関 | 銀行  信用金庫  信用組合  協同組合 | | | | | | | | | | | | | 支店 | | | | | | 口座名義 | フリガナ | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| 金融機関番号 | |  | |  | | |  | |  | | | 支店番号 | | | | | | | 1　普通  2　当座 | 口　　座　　番　　号 | | | | | | | | | | | | | | | | |
|  | | |  | |  | |  | |  | | |  | | |  | | |  | |  | |  | |
| 年　　月　　日  東京都知事　殿 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 対象者 | | | | | |  | | | | 郵便番号 | | | | | | | | | | | 電話番号　　　（　　　） | | | | | | | | | | | | | | | |
| 住所 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| フリガナ  氏名  　　　　　　　　　　（　　　　　年　　　月　　　日生） | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 代行者 | | | | | |  | | | | 住所 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏名 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 続柄　（　　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | (注)1　保険の療養費支給決定通知書、領収書等を添えて申請してください。  　 　 なお、医療保険での付加給付のある人は必ず申し出てください。  2　対象者が未成年の場合は、国民健康保険の世帯主(組合員)又は社会保険の被保険者(組合員)が申請代行者となります。  3　口座振込の場合は、対象者以外の口座には振込できませんので注意してください。  4　保険者番号は右詰めで、記入してください。  5　申請書の記入漏れがないようお願いします。 |
| 決定通知書送付先が対象者の住所と相違する場合のみ記入〈相続人を含む。〉 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 送付先 | | | | | |  | | | | 郵便番号 | | | | | | | | | | | 電話番号　　　（　　　） | | | | | | | | | | | | | | | |
| 住所 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏名 | | | | | | | | | | | | | | | | | | | | | | | | | | |
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（日本工業規格Ａ列3番）