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 |  |  |
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| 年　月 | 日～　日 | 入・外 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 年　月 | 日～　日 | 入・外 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 年　月 | 日～　日 | 入・外 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 合 計 | 件 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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 |
| 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 　  |
|  |

（日本工業規格Ａ列3番）