様式第6号(第9条関係)

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| **重度心身障がい者医療費助成金請求書**  年　　　月　　　日  （あて先） 甲 斐 市 長 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 受給者 住所 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏　名 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受給者にかかる医療費（保険診療に係るもの）の助成を受けたく、助成金の額を証する書面を添えて請求します。なお、助成金の支払いに必要な事項について、市が医療機関及び保険者に照会することを了承します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 診療年月 | | | 令和　　　年　　　月 | | | | | | | | | | |  | | | | 請求金額 | | | | | | | | | | | 円也 | | | | | | | | | | | | | | | | | |  | | |
| ※医療機関等が証明する場合は、太線内に記入をしてください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療報酬請求証明書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 入院・外来の別 | | □入院  □入院外 | | | | 日間 | | | | | |  | | 種別 | | | | | | □国保 □健保 □船員 □共済 □組合 □後期 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| □本人 □家族 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 区　　　分 | | | □1.医科　□3.歯科　□4.調剤 | | | | | | | | | | | | | | | | | □2.補装具　□5.訪問看護  □6.ｱﾝﾏ･ﾏｯｻｰｼﾞ、整骨院　□7.鍼灸□8.柔道整復、接骨院  ※10割を記入 | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  | 診療報酬総点数 | | | 点 | | | | | | | | | | | | | | | | | 円 | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  | 他法公費負担額  (種別　 　　　) | | | 円 | | | | | | | | | | | | | | | | | 円 | | | | | | | | | | | | | | | | | | | | | | | 負担率 | | | | | | |
|  | 保険診療に係る  自己負担額 | | | 円 | | | | | | | | | | | | | | | | | 円 | | | | | | | | | | | | | | | | | | | | | | | 割 | | | | | | |
|  | 高額療養費 | | | 円 | | | | | | | | | | | | | | | | | 円 | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
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|  | 入院時食事療養費における自己負担分 | | | | | | | | | | 単 価 | | | | | | 円 | | | | | | | | × | | | 回 数 | | | | | | 回 | | | | | ＝ | | | 円 | | | | | | | |  |
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| 上記のとおり相違ありません。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 患者氏名  　　　　　 　　様 | | | | | | | | | | | 医療機関コード | | | | | | | | | | | |  | | |  | | |  | | |  | | | |  |  | | |  | | |  | | |  | |  | |  |
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|  | 医療機関等の  所在地・名称 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | 市町村受付印 | | | | | | | | | | | | | | | | |
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|  | 処方箋発行元 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | | | | | | | | |
|  | 医療機関コード | | |  | |  | |  |  | | |  | |  | | | | |  | | |  | |  | | | | |  | | | |  |  | | | | | | | | | | | | | | | | |
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