

**Form A****様式 A****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 health insurance benefit.  
この様式は患者の健康保険の給付の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.  
この様式は担当医が記入し、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.  
各月毎、また入院・入院外毎につき、この様式1枚が必要です。

**Attending Physician's Statement****診療内容明細書**

1. Name of Patient (Last, First) 患者名 _____	Age (Date of birth) 年齢(生年月日) _____	Sex (Male · Female) 性別 <u>男</u> · 女
2. Date of first Diagnosis 初診日 _____	3. Days of Diagnosis and Treatment 診療日数 _____ days	

4. Name of Illness or Injury preferably with the number of International Classification of Diseases for the use of Health Insurance. (Please refer to the table attached to this form.)	傷病名及び健康保険用国際疾病分類番号  (No. _____)
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5. Type of Treatment	治療の分類
	<input type="checkbox"/> Hospitalization 入院 From . . . to . . . ( days) 自 . . . 至 . . . ( 日間) <input type="checkbox"/> Outpatient or Home Visit 入院外 _____ _____ _____

6. Nature and Condition of Illness or Injury (in brief)	症状の概要
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7. Prescription, Operation and any other Treatments (in brief)	処方、手術その他の処置の概要
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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。 <input type="checkbox"/> Yes <input type="checkbox"/> No
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9. Itemized amounts paid to Hospital and/or Attending Physician : Fill in Form B	医療機関、または担当医に支払った医療費の内訳：様式 B による
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## 10. Name and Address of Attending Physician 担当医の名前及び住所

Name	Last(姓)	First(名)	Title(称号)
Address	Home(自宅)		Phone(電話)
	Office(病院または診療所)		Phone
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