Form A
様式　A

1．This form is used for claiming the social insurance benefit.
この様式は、社会保険の給付の申請に使用されます。
2．This form should be completed and signed by the attending physi
この様式は担当医が書き、かつ署名して下さい。
3．One form for each month, one form for hospitalization / outpatient and home visit
各月毎、入院・入院外毎に付この様式が１枚必要です。

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 ______________ 年令（生年月日）______________ 性別（男・女）

2．Name of Illness or Injury preferably with Number of International Classification of Diseases for the use of Social Insurance (See the other side of this form)
傷病名及び社会保険表彰用国際疾病分類番号《別紙参照》

3．Date of First Diagnosis：　________ , 20______

4．Days of Diagnosis and Treatment：________ days
診療日数

5．Type of Treatment
治療の分類

☐ Hospitalization　From ________ , 20______ to ________ 20______ (　　days)
入　　院　自　至　(　　日間)

☐ Out patient or Home Visit：________ , 20______ ________ , 20______
入　院　外　________ , 20______ ________ , 20______

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☐
治療は事故の障害によるものですか。　はい　いいえ

9．Itemized amounts paid to Hospital and / or Attending physician：Form B
治療実費　様式B

１０．Name and Address of Attending Physician
担当医の名前及び住所

Name 名前　：Last 姓 ______________ First 名 ______________

Address 住所：Home 自宅 ______________ Phone ______________

Office 病院又は診療所 ______________ 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