

Request to Attending Physician  
 担当医へのお願い

- 1. Please fill out this form so that the patient may claim health insurance benefits.  
 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 for each hospitalization / outpatient visit (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。

Form B  
 様式 B

Itemized Receipt  
 領収明細書

1. Initial Office Visit	初診料	_____
2. Follow-Up Office Visit	再診料	_____
3. Home Visit	往診料	_____
4. Hospitalization	入院費	_____
5. Consultation	診察費	_____
6. Operation	手術費	_____
7. Nursing Fee	職業看護師費	_____
8. X-Ray Examination	X線検査費	_____
9. Tests Performed	諸検査費	_____
*Please provide details below		_____
		_____
		_____
10. Medications	医薬費	_____
*Please provide the name and dosage for each medication		_____
		_____
		_____
11. Treatments/Procedures	処置費	_____
12. Surgical Dressings	包帯費	_____
13. Anesthetics	麻酔費	_____
14. Operating Room Charge	手術室費用	_____
15. Other (Please specify)	その他(特記せよ)	_____
		_____
16. Total	合計	_____

Currency Unit

通貨単位

IMPORTANT : Exclude any irrelevant costs to the treatment, i.e., payment for private/deluxe room.

注意 : 特別室料等、治療に直接関係のないものは除いてください。

ATTENDING PHYSICIAN INFORMATION 担当医情報欄

Medical Institution Name: (医療機関名)

Address: (住所)

Name of Physician: (担当医名)

Title: (称号)

Signature: (署名)

Phone: (電話)

Date Completed: (作成年月日)

様式 B 邦訳

9. 諸検査費の内訳(諸検査の内容)

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10. 医薬費の内訳(薬の名称、量)

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15. 特記事項

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翻訳者

住所

氏名

印

電話