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| **国民健康保険療養費支給申請書** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 被保険者  記号・番号 | 長 |  |  |  | |  | |  |  | |  | | | 療養を  受けた  被保険者 | | | | 氏 名 | | | | | | | | | | | | | | | | | | | | | | | | | 世帯主と  の続柄 | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | |  | | | | | | |
| 傷病名 |  | | | | | | | | | | | | | 生年月日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 昭和 ・ 平成 ・ 令和　　　年　　　月　　　日　生 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 発症負傷日 | 年 　 　月 　　日 | | | | | | | | | | | | | 個人番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 傷病名又は  負傷の原因 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 療養を受けた  病院、診療所  薬局等の名称  及び所在地 | 名 称 | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医療機関コード | | | | | | | | | | | | | |  | | |  | |  | | |  | | |  | |  | | | |  | | | |  | |  | | | |  | |
|
| 所在地 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 公費法別 | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | |
| 療養の給付を  受けることが  できなかつた  理　　　　由 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 療養を受けた  期　　　　間 | A 入院  B 外来 | | | | 年　　　月　　　日　から  　　　年　　　月　　　日　まで　　日間  （意見書：　　　　　年　　　月　　　日） | | | | | | | | | | | | | | | | | | | | | 傷病の経過 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 口座振込 | 銀行  信金  農協 | | | | | | | | |  | |  |  | |  | 種　別 | | | 口座番号 | | | | | | | | | | | | | 名義人（カタカナ） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 支店 | | | | | | | | |  | |  |  | |  | １普 | ２当 | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | | |  | | |  | |  | | | |  | | | |  | |  | | | |  |
| 備　　　考 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 上記のとおり申請します。  　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　令和　　　年　　　月　　　日  長岡京市長　様  （世帯主）  住所　　長岡京市  氏名  個人番号  電話　（　　　　　）　　　　　　－ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 委任欄 | 本申請に基づく療養費の受領を　　　　　　　　　　　に委任します。　氏名　　　　　 　　　　　　　㊞ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

第１１号様式（第２４条関係）

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| ※処理欄 | 作成履歴 | 無・有（　　年　　月　　　　　　　　　　　　　） | ※市役所計算欄 | |
| 費用額 | 円 |
| 公費41～45 | 無・有（医療係：済・未） | 給付額 | 円 |
| 未納 | 無・有（窓口・領収書記入　　　　　　　　　　　） | 自己負担額 | 円 |
| 療養を受けた理由 | 1. 一般の傷病等 　 2. 第三者行為による傷病等  3. 業務上の傷病等　　4. その他（　　　　　　　　 ） | 高額療養費 | 該当・非該当 |