Form A

1, This form is used for claiming the health insurance benefit.
この様式は健康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 physician.
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、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) (患者名) _____ Sex (性別) Male ・ Female (男性) (女性) Age (年令) _____ Date of Birth (生年月日) ___/___/___ Month Day Year

2, Name of Illness or Injury preferably with Number of International Classification of Diseases for the use of Long-term Care Insurance (See the Form D) (傷病名及び後期高齢者医療制度用国際疾病分類番号(FormD参照))

_____ No. _____

3, Date of First Diagnosis (初診日) ___/___/___ Month Day Year

4, No. Days of Visit / Treatment (診療日数) _____ Days

5, Type of Treatment (治療の分類)

☐ Hospitalization(入院)

From ___/___/___ Month Day Year , to ___/___/___ Month Day Year _____ Days

☐ Out patient or Home Visit (入院外)

From ___/___/___ Month Day Year , to ___/___/___ Month Day Year _____ Days

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 ?
(治療は事故の傷害によるものですか?) ☐ Yes ☐ No

9, Breakdown of Medical Expenses Paid to Hospital and / or Attending Physician : Please fill out Form B
(病院/主治医に支払われる医療費の内訳 : Form Bにご記入ください。)

ATTENDING PHYSICIAN INFORMATION (担当医情報欄)

Medical Institution Name (医療機関名) _____

Address (住所) _____ Phone (電話番号) _____

Name of Physician (担当医氏名) _____ Title (称号) _____

Medical Record Number (診療録番号) _____ Date (記入日) ___/___/___ Signature (署名) _____

※ Attending Physician (担当医)