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 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・入院外毎に付この様式１枚が必要です。

Attending Physician's Statement
診療内容明細書

1. Name of patient (Last, First)　　Age (Date of Birth)　　Sex (Male/Female)

患者名＿＿＿＿＿＿＿＿＿＿＿＿＿＿年齢（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 attached paper)
   傷病名及び社会保険用国際疾病分類番号（別紙参照）

3. Date of First Diagnosis: ＿＿＿＿＿＿＿＿ , ＿＿＿＿＿＿＿＿
   初診日

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

5. Type of Treatment
   治療の分類
   ☐Hospitalization: From ＿＿＿＿＿＿ , ＿＿＿＿＿＿ to＿＿＿＿＿＿ , ＿＿＿＿＿＿(days)
   入院　　自　　至
   ☐Out patient or Home Visit:＿＿＿＿＿＿ , ＿＿＿＿＿＿　　＿＿＿＿＿＿ , ＿＿＿＿＿＿
   入院外　　＿＿＿＿＿＿ , ＿＿＿＿＿＿　　＿＿＿＿＿＿ , ＿＿＿＿＿＿

6. Nature and Condition of Illness or Injury (in brief)
   症状の概要

7. Prescription, operation and any other treatment (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＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

Form B
様式 B

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Itemized Receipt
領 収 明 細 書

(1)	Fee for Initial Office Visit	初　診　料	$
(2)	Fee for Follow-up Office Visit	再　診　療	$
(3)	Fee for Home Visit	往　診　料	$
(4)	Fee for Hospital Visit	入院管理料	$
(5)	Hospitalization	入　院　費	$
(6)	Consultation	診　察　料	$
(7)	Operation	手　術　料	$
(8)	Professional Nursing	職業看護婦費	$
(9)	X-Ray Examinations	X線検査費	$
(10)	Laboratory Tests	諸検査費	$
(11)	Medicines	医　薬　費	$
(12)	Surgical Dressing	包　帯　費	$
(13)	Anesthetics	麻　酔　費	$
(14)	Operating Room Charge	手術室費用	$
(15)	The Others (Specify)	その他（特記せよ）	$ $
			$
			$
(16)	Total	合　計	$

Important: Exclude the amount irrelevant to the treatment, i. e, payment for luxurious room charge.
注意　：高級室料等治療に直接関係のないものは除いて下さい。

Name and Address of attending physician/Superintendent of Hospital or Clinic
担当医又は病院事務長の名前及び住所

Name　：Last姓 First名 Title

Address: Home自宅 Phone

Office病院又は診療所 Phone

Date: 日付　　Signature 署　名