様式第5(第5条関係)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 受付番号 | | | | |  | | | | | | | | | | | | | | |  | 太わく内は必ず本人が記入してから証明を受けてください。 |
|  | | | こども医療費助成金支給申請書  　鹿児島市長　殿　　　　　　　　　　　　　　　　　　　　　　　　　　　　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| こども | フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | 受給者番号 | | | | | | | | | | | | | | | | | |  |
| 氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | |  | |  | | |  | |  | |  | | |  |  |
| 生年月日 | | | | | 年　　　　　月　　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | 連絡先 | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| 受給者  (保護者) | フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所  　　　鹿児島市 | | | | | | | | 丁目  町 | | | | | | | | | | | | 番　　　　　　　号  番地 | | | | | | | | | | | 連絡先の電話番号 | | | | | | | | | | | | | | | | | |
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| 加入医療保険 | 医療保険者番号 | | | | | | | |  | | |  | |  | | |  | |  | | | |  | |  | |  | | 被保険者氏名 | | |  | | | | | | | | | | | | | | | | | |
| 医療保険者名 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 注　医療保険者番号とは、医療保険者を識別する番号です。保険証を見て、右づめで記入してください。(個人の記号番号ではありません。) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険医療機関等の証明 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 患者名  (助成対象者名) | |  | | | | | | | | | | | | | | | | | | | | | | | | | | 生年月日 | | | 年　　月　　日 | | | | | | | | | | | | | | | | | | |
| (診療月)  年　　月分 | | 保険診療総点数 | | | | | | 入院 | | | | |  | |  |  | |  | |  | |  | |  | | 点 | | 保険診療による一部負担金 | | | 入院 | | |  | | |  | |  | | |  | |  | |  | |  | 円 |
| 外来 | | | | |  | |  |  | |  | |  | |  | |  | | 点 | | 外来 | | |  | | |  | |  | | |  | |  | |  | |  | 円 |
| 診療科目 | | 医科・歯科・調剤・柔道整復・補装具等 | | | | | | | | | | | | | | | | | | | | | | | | | | 証明手数料 | | | 円 | | | | | | | | | 公費負担その他 | | | | | | | 有 | | |
| 医療機関コード | |  | |  |  | |  | | |  |  | |  | |  |  | |  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ※番号は右づめで記入してください。  　　　　　年　　月　　日  　保険医療機関等の所在地  　　　　　　　　　名称  　　　　　　　開設者氏名 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

　処理欄

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| 診療月1年以内 | 2,000円控除 | 重複 | 高額該当 | 附加給付該当 | 入力 |
| 可・不可 | 有・無 | 有・無 | ア・イ・ウ・エ・オ・無 | 有(　　　　　　　　)円・無 | 済 |