様式第4号（第6条関係）

（その1）

子ども医療費支給請求書

　小豆島町長　殿

年　　月　　日

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 受給資格者 | 受給者番号 |  |  |  |  |  |  |  |
| 住所 |  | | | | | | |
| 氏名 |  | | | | | | |
| 対象となる子ども | 氏名 |  | | | | | | |

　次のとおり一部負担金を支払いましたので、一部負担金に係る医療費の支給を申請します。

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | 診療報酬等による一部負担額 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 年　　月分 | | | 1　医科　2　歯科　3　調剤　4　その他 | | | | | | | | | | | | | | | | | 1　社保　2　国保 | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 区分 | | | | | | 入院 | | | | | | | | | | | | | 入院外 | | | | | | | | | | | |
| 診療報酬点数 | | | | | |  | |  | | | |  |  | |  | 点 | |  |  | | | |  |  | |  |  | | 点 |  |  |
| 区分 | 他法負担額 | | | | |  | |  | | | |  |  | |  |  | | 円 |  | | | |  |  | |  |  | |  | 円 |
| 保険者負担点数(高額医療分を除く) | | | | |  | |  | | | |  |  | |  |  | | 円 |  | | | |  |  | |  |  | |  | 円 |
| 一部負担額(本人負担額)(注1) | | | | |  | |  | | | |  |  | |  |  | | 円 |  | | | |  |  | |  |  | |  | 円 |
| 入院開始年月日(注2) | | | | | 年　月　日・継続 | | | | | | | | | | | | |  | | | | | | | | | | | |  |
| 本月の入院継続日数又は通院月数 | | | | | 日 | | | | | | | | | | | | | 日 | | | | | | | | | | | |
| 証明年月日　　　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医療機関等の所在地　　　　　　　　　　　　名称及び開設者氏名 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| 注1　一部負担額欄には、食事療養費の標準負担額は含まれません。  　2　入院開始年月日欄には、入院開始月については入院年月日を記入し、前月から引き続き入院している場合には、継続に○印をつけてください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 町事務処理欄 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 本人負担額(A) | | | | 高額療養費 (B) | | | | | | 付加給付額(C) | | | | | | | | | | | 支給決定額  D＝A－B－C | | | | | | | | | |  |
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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 受付年月日 | | 年　月　日 | | |  | | 決裁 | | | |  | | |  | | |  | | | | |  | | |  | | |  | | |  |
| 決裁年月日 | | 年　月　日 | | |
| 支給年月日 | | 年　月　日 | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

　(医療機関等記入欄)