

**Request to Attending Physician (担当医へのお願い)**

1. Please fill in this form so that the patient may claim the national health insurance benefit  
この様式は患者の国民健康保険の給付の申請に必要ですので、証明をお願いします。
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 and one form for hospitalization/outpatient (home visit) should be filled out. 各月毎、入院・入院外毎につき、この様式が必要です。

**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 National Health Insurance  
傷病名及び国民健康保険用国際疾病分類番号 \_\_\_\_\_ (NO. \_\_\_\_\_)
3. Date of First Diagnosis : 

D / M / Y	_ / _ / _
初診日	日 / 月 / 年
4. Duration of Treatment : \_\_\_\_\_ days  
診療日数 \_\_\_\_\_ 日
5. Type of Treatment  
治療の分類  
 Hospitalization : From \_\_\_\_\_, to \_\_\_\_\_ ( days)  
入院 自 \_\_\_\_\_ 至 \_\_\_\_\_ ( 日間)  
 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 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? Yes  No   
治療は事故の傷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による
10. Name and Address of Attending Physician  
担当医の名前及び住所  
Name名前 : Last姓 \_\_\_\_\_ First名 \_\_\_\_\_ Title 称号 \_\_\_\_\_  
Address住所 : Home自宅 \_\_\_\_\_ phone電話 \_\_\_\_\_  
Office病院又は診療所 \_\_\_\_\_ phone電話 \_\_\_\_\_  
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 \_\_\_\_\_