K20-③

RECEIPT (NON-DENTAL)
(領収明細書(一般医科用))

Request to Attending Physician
担当医へのお願い

注意
1. Please fill in this form so that the patient may claim the social insurance benefit. この様式は患者の社会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・入院外毎に付、この様式1枚が必要です。

o Separate receipt required for prescriptions. (薬剤料は別に処方箋を添付のこと)

Name of Illness or Injury (傷病名)

Nature and Condition of Illness or Injury (症状の概要)

Diagnosis and Treatment (診療)

Date of First Diagnosis (初診日) _____

Days of Diagnoses and Treatment (診療を行なった実日数) _____ days (日 間)

Currency paid (支払通貨) _____

Description of Treatment or Operation・Anesthesia
(処置および手術・麻酔の概要)

X-Ray Examinations & Other, Including Number of Times
(レントゲン検査およびその他諸費用)

X-Ray Examinations (レントゲン検査) _____

Other Examinations (その他の検査) _____

_____ _____

Medical Prescriptions (薬剤処方) _____

Hospitalization (入院)

(days)

From _____ To _____

(日間) _____

The Others (その他) _____ _____

Name of Hospital or Clinic (病院又は診療所名称)

_____

Signature of Doctor (担当医署名)

_____

Date (日付) _____

Total (計) _____