別記第26号様式（第21条、第21条の2、第22条、第24条関係）

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|  | | | | | | | | | | | | | | | | | | | | | | | | | 後期高齢者医療療養費支給申請書 | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受付日　　　　　　　　年　　　　月　　　　日  決定日　　　　　　　　年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 保険者番号 | | | **３** | | | **９** | | **１** | | | | **３** | | | **２** | | **２** | | | **３** | | | **８** | | | 個人番号（マイナンバー） | | | | | | | | | | | | | |  | | | |  |  | | |  | |  | | | |  | | |  | |  | |  | | | |  | | |  | |  | | |  |  |
| 被保険者番号 | | |  | | |  | |  | | | |  | | |  | |  | | |  | | |  | | | 療養を  受けた | | | | | 被保険者氏名 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 公費負担者番号 | | |  | | |  | |  | | | |  | | |  | |  | | |  | | |  | | | 生年月日 | | | | | | | | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 公費受給者番号 | | |  | | |  | |  | | | |  | | |  | |  | | |  | | |  | | | 入外区分 | | | | | | | | | 入院・外来 | | | | | | | | | | | | 給付割合 | | | | | | | | | | | | 割 | | | | | | | | | |
| 診療年月 | | | 年　　　月 | | | | | | | | | | | | | | | | | | | | | | | 療養期間 | | | | | | | | | | | 年　　　月　　　日　　　から | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療日数 | | |  | | | |  | | 日 | | | | | | | | | | | | | | | | | 年　　　月　　　日　　　まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 種類 | | | | | | | | | | | 補装具 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | 傷病名 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | 診療を受けた医療機関等の所在地 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | 診療を受けた医療機関名又は施術師 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | 支給申請をした理由 | | | | | | | | | | | 治療に必要な装具を作成したため | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | 発病又は負傷の理由 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | 療養に要した費用額 | | | | | | | | | | |  | |  | | |  | | |  | | |  | | |  | | |  | |  | | | | 食事回数 | | | | | | | | | | | | | | |  | | | |  | | | |  | | |  | | | | | | | | | | | | | | |
| 審査認定額 | | | | | | | | | | |  | |  | | |  | | |  | | |  | | |  | | |  | |  | | | | 療養に要した費用額 | | | | | | | | | | | | | | |  | | | |  | | | |  | | |  | |  | | | |  | | |  | | |  | |  |
| 一部負担金 | | | | | | | | | | |  | |  | | |  | | |  | | |  | | |  | | |  | |  | | | | 食事標準負担額 | | | | | | | | | | | | | | |  | | | |  | | | |  | | |  | |  | | | |  | | |  | | |  | |
| 支給金額 | | | | | | | | | | |  | |  | | |  | | |  | | |  | | |  | | |  | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 該当するものに○を付けてください。該当するものがない場合は（　）内に記載してください。網掛けの中は記載不要です。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 公金受取口座 | | | | **□マイナポータルに登録した公金受取口座を利用します （被保険者本人のみ利用可）**  ※マイナポータルに登録した口座を利用する場合は☑を入れ、振込先口座(下記太枠部)は記入しないでください。  ※公金受取口座を利用できるのは**被保険者本人**のみです。  ※**マイナポータルに口座を登録していない場合や、被保険者本人以外の方の口座は利用できません。** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | 振込先 | 銀行  信用金庫  信用組合  協同組合 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 本店・支店  （　　　） | | | | | | | | | | | | | | | | | | | | | | | | | | 預金種別 | | | | | 普通  当座  （　　　） | | | | | | | | | |  |
|  | | |  | | |  | | | |  | | | |  | | |  | | | | | |  | | |
| 口座番号  （左詰め） | |  | | |  | | | | |  | | | |  | | | |  | | |  | | | | | |  | |  | | |  | | |  | | |  | | | |  | | | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  |
| 口座名義人  （カタカナ） | |  | | |  | | | | |  | | | |  | | | |  | | |  | | | | | |  | |  | | |  | | |  | | |  | | | |  | | | |  | | | | |  | | | |  | | |  | | | | |  | | | |  | | | |  | | |  |
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| 口座名義人欄は、カタカナで上段から左詰めで記入してください。濁点・半濁点は１字として、姓と名の間は１字空けてください。  上記のとおりに療養に要した費用に関する証拠書類を添えて申請します。  　　　　　　　　　　年　　　月　　　日  　東京都後期高齢者医療広域連合長宛  　　　　　　　　　　　　　　　　　　　申請者　　住所  　　　　　　　　　　　　　　　　　　　　　　氏名  　　　　　　　　　　　　　　　　　　　　　　連絡先 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |