様式第14号（その１）

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| 国民健康保険療養費支給申請書 | | | | | | | | | | | | | | | 区分 | | | |  | | | | | | | | | | | | | | | | | |
| 被保険者証 | 記号  　番号 | | | | | 療養を受けた被保険者 | | | 生年月日 | | | | | | 年　　月　　日 | | | | | | | | | | | | | | | | | | | | | |
| 氏名 | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 | | | | | |  | |  | | | |  | |  | | |  | |  | | |  |  |  |  |  |  |
| 傷病名 |  | | | | | 療養期間 | | | | | | | | | 年　　月　　日から  年　　月　　日まで | | | | | | | | | | | | | | | | | | | | | |
| 発病又は負傷年月日 | 年　　月　　日 | | | | |
| 交通事故等の第三者行為 | | | | 有・無 | | 日間 | | | | | | | | | | | | | | | | | | | | | |
| 診療、薬剤の支給又は手当を受けた病院、診療所、薬局その他の者の名称及び所在地 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療又は調剤に従事した医師、歯科医師又は薬剤師の氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 療養の給付又は保険外併用療養費の支給を受けることができなかった理由 | |  | | | | | | 発病の原因 | | | |  | | | | | | | | | | | | した費用  療養に要 | | | | |  | | | | | | | |
| 傷病の経過 | | | |  | | | | | | | | | | | | 円 | | | | | | | |
| 療養内容 | | | |  | | | | | | | | | | | |
| 備考 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 支給金額を下記預金口座へ振込み願います。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 振込先金融機関 | | | 銀行  　　　　　　信用金庫  　　　　　　農協 | | | | 支店 | | | | | | | | | | | 銀行コード | | | | | | | | | | | | | | | | | | |
| フリガナ | | |  | | | | | | | | 口座番号 | | 普通 | | | | |  | | | | | | | | | | | | | | | | | | |
| 名義人(世帯主) | | |  | | | | | | | | 当座 | | | | |  | | | | | | | | | | | | | | | | | | |
| □マイナポータル等で事前登録した公金受取口座を利用します。 | | | | | | | 個人番号 | | | | | | |  | |  | | | |  | |  | | |  | |  | | |  | |  |  |  |  |  |
| ※公金受取口座を利用する場合は☑と右欄に個人番号を記入し、口座情報の記入は不要です。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 上記のとおり、別紙証拠書類を添えて申請します。  　　　　　年　　月　　日  　　　(宛先)所沢市長 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 世帯主 | | | | | | | | | | 住所  氏名  電話  個人番号 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申請者（申請者が世帯主の場合は記入不要） | | | | | | | | | | 住所  氏名  個人番号 | | | | | | | | | | | | | | | | | | | | | | | | | | |

