

Itemized Receipt 領収明細書

(様式B)

Request to Attending Physician	担当医へのお願い
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- O Please fill in this form so that the patient may claim the health insurance benefit. この様式は患者の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。
- This form should be completed and signed by the attending physician.この様式は担当医が記入し、かつ署名してください。

Reference Number of your Medical Record (if applicable) 診療録の番号

O One form for each month and one form for hospitalization/outpatient (home visit) should be filled out. 各月毎、また入院・入院外毎につき、この様式1枚が必要です。

e of Patient(Last , First)患者名				
try 国名		Currency unit 通貨単位		
Ito	em(項目)		Amount(金額)	
Fee for Initial Office Visit		(初診料)		
Fee for Follow-up Office Visit		(再診料)		
Fee for Home Visit		(往診料)		
Fee for Hospital Visit		(入院管理料)		
Hospitalization		(入院費)		
Consultation		(診察費)		
Operation		(手術費)		
Professional Nursing		(職業看護師費)		
X-ray Examinations		(X 線検査費)		
Laboratory Tests (諸検査費)				
Please fill in the content of the				
Laboratory Tests.				
諸検査の内容を記入してください。				
Medicines (医薬費)				
Please fill in the name and the				
amount of the prescription of an				
individual medicine.				
処方した薬の名称と量を記入してください。				
Surgical Dressing		(包帯費)		
Anesthetics		(麻酔費)		
Operating Room Charge		(手術室費用)		
The Others (その他・特記)				
(Specify)				
		Total 合計		
 ※ Important: Exclude the amount irrelevant to the treatment.i.e, payment for a luxurious room charge. 特別室料等、治療に直接関係ないものは除いてください。 Name and Address of Attending Physician 担当医の名前及び住所				
<i>,</i>				
Name 名前 <u>Last 姓</u>	First 名	Title 称号		
Office Address 病院又は診療所の住所				
Office 病院又は診療所の名称		Phone 電話		
Date 日付·	Signature 署名			
	Ite Fee for Initial Office Visit Fee for Follow-up Office Visit Fee for Home Visit Fee for Hospital Visit Hospitalization Consultation Operation Professional Nursing X-ray Examinations Laboratory Tests (諸検査費) Please fill in the content of the Laboratory Tests. 諸検査の内容を記入してください。 Medicines (医薬費) Please fill in the name and the amount of the prescription of an individual medicine. 処方した薬の名称と量を記入してください。 Surgical Dressing Anesthetics Operating Room Charge The Others (その他・特記) (Specify) ロportant: Exclude the amount irrelevant 特別室料等、治療に直接関係ないも me and Address of Attending Physician 担当記 Name 名前 Last 姓 Office 病院又は診療所の名称	Ttem (項目) Fee for Initial Office Visit Fee for Follow-up Office Visit Fee for Home Visit Fee for Home Visit Hospitalization Consultation Operation Professional Nursing X-ray Examinations Laboratory Tests (諸検査費) Please fill in the content of the Laboratory Tests. 諸検査の内容を記入して(ださい。 Medicines (医薬費) Please fill in the name and the amount of the prescription of an individual medicine. 処方した薬の名称と量を記入して(ださい。 Surgical Dressing Anesthetics Operating Room Charge The Others (その他・特記) (Specify) mportant: Exclude the amount irrelevant to the treatment.i.e.p.p.a 特別室料等、治療に直接関係ないものは除いてください。 me and Address of Attending Physician 担当医の名前及び住所 Name 名前 Last 姓 First 名 Office Address 病院又は診療所の名称	Item (項目) Fee for Initial Office Visit (初診料) Fee for Follow-up Office Visit (用診料) Fee for Follow-up Office Visit (用診料) Fee for Home Visit (注診料) Fee for Home Visit (注診料) Fee for Hospital Visit (八院管理料) Hospitalization (八院門) (多家費) Operation (多家費) Operation (手術費) Professional Nursing (職業看護師費) Plasse fill in the content of the Laboratory Tests (諸検査費) Please fill in the content of the Laboratory Tests (諸検査費) Please fill in the name and the amount of the prescription of an individual medicine. (股死費) Please fill in the name and the amount of the prescription of an individual medicine. (財力に変める機能量を記入てださい。 (日本教費) Operating Room Charge (子の他・特記) (Specify) Total 合計 Total 会計 Total	

様式B 翻訳

10. 諸検査費の内訳	
11. 医薬費の内訳(薬の名称、量)
15. その他(特記事項)	
	翻 訳 者
	住 所