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| 様式第３１号（その４）（附則第２項関係） | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
|  |  |  |  | |  | |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| 国民健康保険傷病手当金支給申請書（医療機関記入用） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医療機関担当者が意見を記入するところ | | 患者氏名 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 傷病名 | | | | | | | | | |  | | | | | | | | | | | | 初診日 | | | | | 年 　　月 　　日 | | | | | | | | | | | |
| 発病年月日 | | | | | | | | | | 年　　月　　日 | | | | | | | | |  | | | 発病の原因 | | | | |  | | | | | | | | | | | |
| 労務不能と  認めた期間 | | | | | | | | | |  | | | | | | | | |  | | |
| 年　　月　　日 | | | | | | | | | から | | |
|  | | | | | | | | |  | | |
| 年　　月　　日 | | | | | | | | | まで | | | 基礎疾患の有無 | | | | |  |  |  |  |  |  |  |  |  |  |  |  |
| □ 有（　　　　　　　　　　　　　） | | | | | | | | | | | |
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| □ 無 | | | | | | | | | | | |
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| うち、入院期間 | | | | | | | | | |  | | | | | | | | |  | | | 療養費用の種別 | | | | |  |  |  |  |  |  |  |  |  |  |  |  |
| 年　　月　　日 | | | | | | | | | から | | | □ 国保 | | | | □ 公費（　　　　　　） | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |
| □ 自費 | | | | □ その他（　　　　　） | | | | | | | |
|  | | | | | | | | |  | | |  |  |  |  |  |  |  |  |  |  |  |  |
| 年　　月　　日 | | | | | | | | | まで | | | 転帰 | | | | |  |  |  |  |  |  |  |  |  |  |  |  |
| □ 治癒 | | | | □ 中止 | | | |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| □ 繰越 | | | | □ 転医 | | | |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 診療日及び入院していた日を○で囲んでください。 | | | | | | | | | | 年　月 | | | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |  | 診療  実日数 | | |  | | | 日 | |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
| 年　月 | | | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |  | 診療  実日数 | | |  | | | 日 | |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
| 年　月 | | | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |  | 診療  実日数 | | |  | | | 日 | |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
| 上記の期間中における「主たる症状及び経過」「治療内容、検査結果、療養指導」等（詳しく） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | 手術年月日 | | | | | 年　　　月　　　日 | | | | | | | | | | | |
| 退院年月日 | | | | | 年　　　月　　　日 | | | | | | | | | | | |
| 症状経過から見て従来の職種について労務不能と認められた医学的所見 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 上記のとおり相違ありません。 | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  | |  | |  | |  | |  |  |  | 〒　　　　－ | | | | | | | | | |  |  | 年　　　月　　　日 | | | | | | | | | | | | |  |
|  | | 医療機関の所在地 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 医療機関の名称 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 医師の氏名 | | | | | | | | | | |  | | | | | | | | | | |  |  | 電話番号 | | | |  | | | | | | | | |