Form B

1, This form is used for claiming the health insurance benefit.
この様式は健康保険の給付の申請に使用されます。

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, one form for hospitalization/outpatient and home visit.
各月毎、入院・入院外毎に、この様式が1枚必要です。

Itemized Receipt
領収明細書

1, Fee for Initial Office Visit	(初診料)	
2, Fee for Follow-up Office Visit	(再診料)	
3, Fee for Home Visit	(往診料)	
4, Fee for Hospital Visit	(入院管理料)	
5, Hospitalization	(入院費)	
6, Consultation	(診察費)	
7, Operation	(手術費)	
8, X-Ray Examinations	(X線検査費)	
9, Tests Performed	(諸検査費)	
※ Please provide details below	※以下に検査内容の詳細を記入してください。	
10, Medicines	(医薬費) ※以下に薬品名・投与量を記入してください。	
※ Please provide the name and dosage for each medication		
11, Anesthetics	(麻酔費)	
12, Operating Room Charge	(手術室費用)	
13, Other (Please specify)	(その他 特記)	

Total _____ Currency Unit (通貨単位)

Important

Exclude any irrelevant costs to the treatment, i. e. payment for private/deluxe room.
注意） 高級室料・特別室料などの治療に直越関係ないものは除いてください。

ATTENDING PHYSICIAN INFORMATION (担当医情報欄)

Medical Institution Name (医療機関名) _____

Address (住所) _____ Phone (電話番号) _____

Name of Physician (担当医氏名) _____ Title (称号) _____

Medical Record Number (診療録番号) _____ Date (記入日) ___/___/___ Signature (署名) _____

※ Attending Physician (担当医)