別記第6号様式（第6条関係）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **養　育　医　療　給　付　台　帳** | | | | | | | | | | | | | | | | | | 受給者 番　号 | |  | |  | |  |  |  | |  |  | | | 公費負担者番号 | | | | | | | |  | | | | |
| フリガナ | | | |  | | | | | | | | 性別 | | | 1　男  2　女 | 生年月日 | | | | | 住所 | | | 〒 |  |  | |  | － | |  | | |  | | |  | |  | | |  | | |
| 受給者 氏　名 | | | |  | | | | | | | |
| ・　　　　・ | | | | |  | | | | | | | | | | | | | | | | | | | | |
| フリガナ | | | |  | | | | | | | | 続柄 | | | 1　父 | 3　祖父 | | 5　その他 | | | 住所 | | | 〒 |  |  | |  | － | | |  | | |  | | |  |  | | | | 電話番号 | |
| 申請者 氏　名 | | | |  | | | | | | | |
| 2　母 | 4　祖母 | | （　　　　） | | |  | | | | | | | | | | | | | | | | | | |  | |
| 保険種別 | | | |  | | | | | 保険者名 | |  | | | | | | | 保険証 | | | 記号 | | |  | | | | | | 番号 | | |  | | | | | | | | | | | |
| 子ども医療費 受給者証番号 | | | | | | | | | 指定養育 医療機関 | | 名　称 | |  | | | | | | | | | | | | | | | | | 出　生　時　体　重 | | | | | | | | | | | 意　見　書　所　見 | | | |
|  |  |  | |  |  |  | |  | 所在地 | |  | | | | | | | | | | | | | | | | | ｇ | | | | | | | | | | |  | | | |
| 医　療　券 交付年月日 | | | | | | 医　療　券　有　効　期　間 | | | | | | | | | | | 診　療　予　定　期　間 | | | | | | | | | | | | | 所得税額 | | | | | | | | | 階層  区分 | | | | | 徴収月額 |
| ・　　・ | | | | | | ・　　　・　　　　～　　　　・　　　・ | | | | | | | | | | | ・　　　・　　　　～　　　　・　　　・ | | | | | | | | | | | | | 円 | | | | | | | | |  | | | | | 円 |
| 請求月 | | | 診療月 | | | | 診　療 実日数 | | | 決定点数 ① | | | | 医療保険等  負担額　② | | | 差引額 ①－②＝③ | | 移送費等 ④ | | | | その他 ⑤ | | | | 支弁額 ③＋④＋⑤＝⑥ | | | | | | | | | 備　　考 | | | | | | | | |
|  | | |  | | | |  | | |  | | | |  | | |  | |  | | | |  | | | |  | | | | | | | | |  | | | | | | | | |
|  | | |  | | | |  | | |  | | | |  | | |  | |  | | | |  | | | |  | | | | | | | | |  | | | | | | | | |
|  | | |  | | | |  | | |  | | | |  | | |  | |  | | | |  | | | |  | | | | | | | | |  | | | | | | | | |
|  | | |  | | | |  | | |  | | | |  | | |  | |  | | | |  | | | |  | | | | | | | | |  | | | | | | | | |
|  | | |  | | | |  | | |  | | | |  | | |  | |  | | | |  | | | |  | | | | | | | | |  | | | | | | | | |
| 計 | | |  | | | |  | | |  | | | |  | | |  | |  | | | |  | | | |  | | | | | | | | |  | | | | | | | | |