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| 別記第7号様式（第6条関係） | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 養　育　医　療　券 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | （病院・診療所用） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 公費負担者番号 | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | |
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| 被保険者証等 | | | | | | | | | | | | | | | | 記　　号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 番　　号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 受療者 | | | | | | | | | | | | | | | | フリガナ | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 申請者 | | | | | | | | | | | | | | | | フリガナ | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 住所 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 指定養育  医療機関 （病院、診療所） | | | | | | | | | | | | | | | | 名称 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 電話 番号 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 所在地 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療予定期間 | | | | | | | | | | | | | | | |  | | | | | | | | | 年 | |  | | |  | | | | | | 月 | | | |  | |  | | | | 日 | | | から | | | | | | |  | | | | |  | | | |  | 年 | | | | |  | |  | | | | | 月 | | | |  | | | | |  | | | 日 | | |
| この券の有効期間 | | | | | | | | | | | | | | | |  | | | |  | | |  | | 年 | |  | | |  | | | | | | 月 | | | |  | |  | | | | 日 | | | から | | | | | | |  | | | | |  | | | |  | 年 | | | | |  | |  | | | | | 月 | | | |  | | | | |  | | | 日 | | |
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|  | | | 上記のとおり決定します。 | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 母子保健法第２１条の４ の規定により徴収する額 | | | | | | | | | | | | | | | | | | | | | | 基準月額 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | 円 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ※ | | ご負担いただく金額（徴収基準月額）は、養育医療給付申請時に添付された委任状に基づき、養育医療 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 担当課において、子ども医療費の請求及び受領をいたします。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| ※ | | ２人以上のお子さまが同時に養育医療の認定を受けている場合、２人目以降のお子さまについては負担 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 金額が１０分の１となります。ただし、負担金額の全額を適用されているお子さまが先に退院された場合には、入院を継続されるお子さま（のうち、お１人）に負担金額の全額が適用されます。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |