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| 高額介護合算療養費等支給申請書兼自己負担額証明書交付申請書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 申請対象年度 | | | | | | | | | | | | | | 平成　　年度 | | | | | | | | 申請区分 | | | | | | | | | | | | | １．新規 | | | | | | | | | | | | | ２．変更 | | | | | | | | | | | ３．取下げ | | | | | | | | | | | | | | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | | （保険者等記入欄） | | | | | | | | | | | | | | | | | | | | | | | | 支給申請書整理番号 | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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| フリガナ | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 生年月日 | | | | | | | | | | | | | 明治・大正・昭和　　 年　月　日 生 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 性別 | | | | | | | | | | | | 加入期間 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏　　名 | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 男 ・ 女 | | | | | | | | | | | | 年　　月　　日から　　年　　月　　日まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 国民健康保険資格情報 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険者番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 被保険者証記号 | | | | | | | | | | | | | | | | | | | | 被保険者証番号 | | | | | | | | | | | | | | | | | | | 続　柄 | | | | | | | | | | | | | 保険者名称 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 加入期間 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 後期高齢者医療資格情報 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険者番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 被保険者番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 保険者名称 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 加入期間 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 介護保険資格情報 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険者番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 被保険者番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 保険者名称 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 加入期間 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 支給方法 | | | | | | | | | | | | | | 口座管理番号 | | | | | 振込口座記 入 欄 | | | | | | | | | | | | | | 銀行 　　　　　　　信用組合 　　　　　　　信用金庫 　　　　　　　農協 | | | | | | | | | | | | | | | | | | | | | | | 金融機関コード | | | | | | | | | | | | | 本店 　　　　　　支店 　　　　　　出張所 | | | | | | | | | | | | | | | | | | | 店舗コード | | | | | | | | | | | | 種　目 | | | | | | | | | | | | 口座番号 | | | | | | | | | | | | | | | | | | | | | フリガナ | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | 振込先口座 管理番号 | | | | | | | | |
| １．窓口払い ２．口座振込 | | | | | | | | | | | | | |  | | |  | | |  | | | |  | | |  | | |  | | |  | | |  | | | １．普通預金 ２．当座預金 ９．その他 | | | | | | | | | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | | 口　座 名義人 | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
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| 保険者 加入歴 | | | | | | | | | |  | | | | 保険者名 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 加入期間 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 添付の自己負担額証明書整理番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 備考欄 | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| １ | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 年　　月　　日　から 　　年　　月　　日　まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ２ | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 年　　月　　日　から 　　年　　月　　日　まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 小野町長　　　　　　様　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　年　　月　　日  　　①　上記対象者について、高額介護合算療養費（高額医療合算介護（介護予防）サービス費）の支給を申請します。　　　　　　住　所 　　②　上記対象者について、自己負担額証明書の交付を申請します。　　　　　　　　　　　　　　　　　　　　　　　　申請者 　　※自己負担額証明書の交付申請を行う場合、①、②のいずれも丸で囲んでください。　　　　　　　　　　　　　　　　　　　　氏　名　　　　　　　　　　　　　　　　　　　　印 　　　高額介護合算療養費（高額医療合算介護（介護予防）サービス費）の支給申請を行う場合、①のみを丸で囲んで　　　　　　　電話番号 　　　ください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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備　考

１．この用紙は、日本工業規格Ａ列４番とすること。

ご記入上の注意事項等

１．高額介護合算療養費等支給申請について

（１）医療保険の自己負担額と介護保険の自己負担額を合計した結果、一定の限度額を超えた場合に、その超えた額が高額介護合算療養費（高額医療合算介護（介護予防）サービス費）として支給されます。

（２）各資格情報欄については、申請対象年度末（記載年の７月末日）に加入する医療保険（介護保険）の資格情報を記載してください。

（３）国民健康保険資格情報の続柄欄、「２．擬制世帯主」とは世帯員が国保の加入者であるが、世帯主は国保の加入者でない場合を指します。

（４）計算期間の始期及び終期の間に加入する医療保険（介護保険）に変更があった場合、保険者加入歴欄に以前に加入していた医療保険（介護保険）の保険者名称（広域連合名称）と加入期間を記載し、

　　　また同保険者（広域連合）加入時の自己負担額証明書を添付する場合には同証明書整理番号を記載してください。添付する同証明書がない場合には、「添付なし」と記載してください。

　　　なお、申請対象年度末日に加入している医療保険（介護保険）については、当該保険者加入歴欄への記載は不要です。

（５）複数名の支給額の同一口座への振込を希望する場合、該当者の振込口座記載欄（金融機関名から口座名義人まで）は記載せず、振込先口座管理番号欄に希望振込先口座の口座管理番号を記載してくだ

さい。

例）口座管理番号２の被保険者への支給額を、口座管理番号１の被保険者の口座に振り込んでほしい場合、口座管理番号２の被保険者の振込口座記載欄は記載せず、振込先口座管理番号欄に１と記載

する。

（６）備考欄には、以下の内容を記載してください。

　　①国民健康保険、後期高齢者医療の被保険者

　　　・当該医療保険者（広域連合）の所在地、及び同医療保険者における計算期間内の受診歴（以前に加入していた医療保険者における受診歴は記載する必要はありません。）

　　②健保組合等被用者保険の被保険者で介護保険の被保険者

・健保組合等被用者保険の名称、所在地、及び同保険者における計算期間内の受診歴

　　③死亡・海外移住・生保適用等により計算期間の途中に被保険者資格を喪失した者（ただし、介護保険適用除外施設入所、他保険者への転出による資格喪失者を除く）

　　　・被保険者資格を喪失した年月日、被保険者資格を喪失した事由

（７）国民健康保険における高額介護合算療養費は、世帯主・世帯員の支給合計額が世帯主（擬制世帯主）の口座に振り込まれることとなりますので、ご留意ください。

（８）２名を超える対象者を記載する場合等、複数枚に渡ることがわかるよう、右下の頁欄に全体の枚数と何枚目かを記載してください。

（９）介護保険被保険者証が交付されていない介護保険被保険者については、介護保険情報（保険者番号、被保険者番号、保険者の名称、加入期間）の記載は不要です。

（１０）介護保険で給付制限を受けており、自己負担が３割となっている方については、その給付制限期間中は自己負担額が零として計算されることとなり、高額医療合算介護（介護予防）サービス費の支

　　　給ができない場合があります。

２．自己負担額証明書交付申請について

（１）自己負担額証明書の交付を申請する場合、必ず同じ市町村の保険者番号を記載してください（２以上の市町村の保険者番号を記載しないでください）。

（２）各医療保険（介護保険）資格情報ごとに、複数保険者分の自己負担額証明書が必要である場合、それぞれの保険者へ申請する必要があります。

保険者記入上の注意事項

１．複数枚に渡る支給申請の受付時において、右上の支給申請書整理番号には提出者単位で同一の番号を記載すること。

２．支給申請書整理番号は以下の番号体系とすること。

　　「ＧＹＹ（申請対象年度和暦、平成の場合、Ｇは“４”）＋保険者番号８桁（国保保険者の場合、先頭２桁を“００”とし、介護保険者の場合、先頭２桁を“９９”とする）＋保険者が付する通し番号８桁」（計１９桁）

　　なお、保険者が付する通し番号は、申請対象年度ごとに申請受付順に１から付番すること。