様式第4号

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| 医療機関コード | | | | | | | |  | | | |  | |  | | | | |  | | | |  | | | |  | | | |  | | | |  | | |  | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受給者番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 区 | | | | | | | | | | | 診療年月 | | | | | | | | | | | | | | | 診療実日数 | | | | | | 支給決定額A－  (B＋C＋D) | | | | | | | | | | | | | | | | | |
|  | | |  | | |  | | | |  | | | | | |  | | | | |  | | | |  | | | | 1　入  2　外  3　食 | | | | | | | | | | |  | | | |  | | | | |  | | |  | | |  | | |  | | | |  | |  | | | |  | | |  | | |  | | | 円 | |
| 保険診療金額  A | | | | | | | | | | | | | | | | | | 法定負担額  B | | | | | | | | | | | | | | | | 附加給付額  C | | | | | | | | | | | | | その他の控除  D | | | | | | | | | | | | | 種別 | | | | | 本人負担額 | | | | | | | | | | | | | |
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| 子ども医療費助成申請書    令和　　　年　　　月　　　日  　鯖江市長　　　　　　殿  住所  申請者  (保護者)　　氏名 | | | | | | | | | | | |
| 子ども | 受給者番号 |  |  |  |  |  |  |  | 加入医療保険 | 被保険者氏名 |  |
| フリガナ  氏名 |  | | | | | | | 記号番号 |  |
|  | | | | | | | 発行機関名 |  |
| 保険種別 | 国保・退職・協会・健組・船員・国組・私学共・国公共・地公共・その他 |
| 生年月日 | 年　　　月　　　日 | | | | | | | 負担区分 | 本人・家族 |
| 附加給付等の有無 | 有・無 |

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| 保険医療機関等証明欄(領収書) | | | | | | | | | | | | | | |
| 診療区分 | 医科 | | | 歯科 | | | | | | | 調剤 | | 柔整・ | その他  (　　) |
| 入院 | 入院外 | | 入院 | | | 入院外 | | | |
| 年　　　　　月分 | | | 診療実日数 | | | | | | 日 | | | | | |
| 保険診療点数 | 点 | | 保険負担割合 | | 割 | | | 本人負担額 | | | | 円 | | |
| 入院時食事療養費標準負担額 | | | | | | 1食 | | | | 円 | | | | |
| 上記のとおり証明する。  　　令和　　　年　　　月　　　日  医療機関等の所在地および名称  開設者氏名　　　　　　　　　　　印 | | | | | | | | | | | | | | |