支部様式第11号

地方公務員災害補償

診　療　費　請　求　書

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| 地方公務員災害補償基金千葉県支部長　様 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 下記の診療費を請求します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 郵便番号 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 所 在 地 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 医療機関の 　名　　称 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 氏　　名 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
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| （請求金額の内訳は裏面のとおり） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **※認 定 番 号** | | |  | | | | | | | | | | | | | **ふりがな** | | | | | | | |  | | | | | | |  |
| **※氏 名** | | | | | | | |  | | | | | | |
|  | **※所属団体部局** | | |  | | | | | | | | | | | | |  |
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|  | 送金先 | 振込先銀行 | | | | |  | | | | | | | | | | | 銀行 | | |  | | | | | | | | | 支店 | |  |
|  | 預金種目 | | | | | 普通 当座 | | | | | | | | 口座番号 | | | | | | |  | | | | | | | | | |  |
|  | 振込口座 | | | | | 住　　所 | | | | |  | | | | | | | | | | | | | | | | | | | |  |
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|  | 預金名義 | | | | |  | | | | | | | | | | | | | | | | | | | |  |
| （預金名義は、省略せずに通帳の記載どおりに記入してください。）   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 決定金額 |  | | | | | | 円 | | | 通　　知 |  |  | 年 |  | 月 |  | | 日 | | 支　　払 |  |  | 年 |  | 月 |  | | 日 | |  | | | 受　付　印 | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

注１　医療機関の方へ……



(1) この請求書は、医療機関との契約（協定）に基づき、公務上又は通勤により

負傷又は疾病にかかった地方公務員が診療を受ける際使用するもので、診療に

要した費用は、地方公務員災害補償基金千葉県支部から口座振替の方法により

直接支払いますので、本人には請求しないでください。

(2) この請求書は、被災職員別に作成し、月ごとに翌月の10日までに、

〒261-7133 千葉市美浜区中瀬2-6-1WBGﾏﾘﾌﾞｳｴｽﾄ33階　地方公務員災害補償基金

千葉県支部に提出してください。

(3) 診療費は協定料金により支払います。

(4) 請求に当たり疑義がある場合は、地方公務員災害補償基金千葉県支部（TEL043-350-2112）に

お問い合わせください。

注２　被災職員（所属事務担当者）の方へ……

(1) この請求書は、地方公務員災害補償基金千葉県支部の指定医療機関で受診する場合にのみ

使用してください。

(2) この請求書は、初診日及び療養を継続している場合には毎月20日頃までに、指定医療機関に  
必ず提出してください。

(3) ※印欄は、被災職員（または所属事務担当者）が必ず記入してください。

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| **※所属事務担当者** | **係 名** |  | **氏 名** |  | **電 話** |  |

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| 診 療 費 請 求 明 細 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( | |  | | | | | 床) |
| 傷病名 | | | | ア | |  | | | | | | | | | | | | | | | | | | | | | | | 診療開始日 | ア |  | | |  | | 年 | | |  | | | 月 | | |  | | | 日 | |
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| 傷  病 経  の 過 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | 診療期間 |  | |  | | | 年 | | |  | | 月 | | |  | | | | 日から | | |
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| 診　　療　　内　　容 | | | | | | | | | | | | | | | | | | | | | | | | | | 点　　数 | 金　　額 | | 診療実日数 | 日 | | | 診療日 | | | | 1 2 3 4 5 6 7 8 9 10 31  11 12 13 14 15 16 17 18 19 20 31  21 22 23 24 25 26 27 28 29 30 31 | | | | | | | | | | | | |
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| 病･診･衣 | | | | 入院基本料・加算 | | | | | | | | | | | | | | | | | | | | |  |  | |
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| 特定入院料・その他 | | | | | | | | | | | | | | | | | | | | | | | | |  |  | |  | | | | | | | | | | | | | | | | | | | | |
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| 診療報酬点数表により計算できないもの  　例えば診断書料・入院室料差額等  　　　　明細は文書料・入院室料差額等証明書の通り | | | | | | | | | | | | | | | | | | | | | | | | | | (6) | | 円 | （注）文書料・室料差額証明書（支部様式第12号） を添付してください。 | | | | | | | | | | | | | | | | | | | | |
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| 診療費請求合計額（５）＋（６） | | | | | | | | | | | | | | | | | | | | | | | | | |  | | 円 |  | | | | | | | | | | | | | | | | | | | | |