English/英語

患者氏名 ：
患者 ID ：

# Medical Expense Receipt

Date issued (YYYY/MM/DD) : ____/____/____

**Hospital name:** ☐**Outpatient** ☐**Inpatient** ☐**Second opinion**

**Department：** **Insurance type:** **(Percentage of patient liability: %)**

Billing period: From ____/____/____ to ____/____/____

**Hospital ID No.:** **Patient name:**

| | First/subsequent visit fees | Admission charges, etc. | Diagnostic procedure combination (DPC) | Medical supervision charges, etc. | Home medical care |
|---|---|---|---|---|---|
| Insurance points | | | | | |
| Patient liability | ¥ | ¥ | ¥ | ¥ | ¥ |
| | **Examinations** | **Diagnostic imaging** | **Medication** | **Injections** | **Rehabilitation** |
| Insurance points | | | | | |
| Patient liability | ¥ | ¥ | ¥ | ¥ | ¥ |
| | **Specialized psychiatric treatment** | **Medical treatment** | **Surgery** | **Blood transfusion** | **Anesthesia** |
| Insurance points | | | | | |
| Patient liability | ¥ | ¥ | ¥ | ¥ | ¥ |
| | **Radiotherapy** | **Pathological diagnosis** | **Dental crown restoration / Prosthodontics** | **Prescriptions** | **SUBTOTAL** |
| Insurance points | | | | | |
| Patient liability | ¥ | ¥ | ¥ | ¥ | ¥ |

| | Dietary therapy | Documentation | Delivery charges | Extra room charges | Special or specified medical care |
|---|---|---|---|---|---|
| Patient liability | ¥ | ¥ | ¥ | ¥ | ¥ |
| | **Others** | | | | **SUBTOTAL** |
| Patient liability | ¥ | | | | ¥ |

Comments：

| Sales tax | | **TOTAL RECEIVED** |
|---|---|---|
| Subtotal to be taxed | Tax | |
| ¥ | ¥ | ¥ |