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| |  | | --- | |  | | ９９９－９９９９  ●●県●●市●●１－２－３  あいうえおかきくけこ  ■■　太郎　様  （▲▲　花子　様分）  （1234567890） | |  | | ●●市介護保険課  123-4567　●●市●●１－２－３  電話番号　987-6543-2111  FAX番号 　123-456-7890  メール　　xxxxxxxxxxx@yyy.zzz.aaa | |  |   **自由記載１**  **固定文言１** | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | 第　　　　　　号  年　月　日 | | | | | | | | **介護給付費通知書**  印 | | | | | | | | ○○市（町村）長 | | | | | | | | 被保険者番号： | | | 被保険者氏名： | | | | | あなたの　　　　　年　　日　～　　　　　年　　日　における給付費は  **固定文言２＋編集１**  以下のとおりです。 | | | | | | | | サービス  月 | サービス  事業所 | サービス種類  ／サービス略称 | | 利用者負担  合計額  （円） | サービス  費用合計額  （円） | **固定文言３**  備考 | |  |  |  | |  |  | **固定文言４**  **＋編集２** | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | | | | | | | サービス  月 | サービス  事業所 | サービス種類  ／サービス略称 | 利用者負担  合計額  （円） | サービス  費用合計額  （円） | **固定文言３**  備考 | |  |  |  |  |  | **固定文言４**  **＋編集２** | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | | ※この通知は、利用された介護サービスの費用額や種類を確認いただくための  ものであり、費用の請求や支払等を行う必要はありません。  ※サービス費用合計額は、あなたが介護サービスを受けたときにお支払いに  なった金額を含む総額を記載しています。 | | | | | |   **固定文言５** |