**高額介護予防サービス費相当事業費支給（不支給）決定通知書**

**（サービス提供年月別明細）**

様式番号

被保険者番号：　　　　　　　　　被保険者氏名：

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| サービス  提供年月 | 給付の種類 | 支給可否 | 本人支払額 | 支給金額 | **固定文言１**  備考 |
|  |  |  |  |  | **固定文言２＋編集１** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**自由記載１**

（　　　　／　　　　）