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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 | | | | | | | | | | **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**  印 | | | | | | | | | | ○○市（町村）長  **固定文言２＋編集１** | | | | | | | | | | 申請年月日に申請のありました給付費については、次のとおり決定しましたので通知します。 | | | | | | | | | |  | 被保険者番号 | |  | | | | |  | | 被保険者氏名 | |  | | | | | | 決定年月日 | |  | | | | | | 本人支払額合計 | |  | | | | | | 支給金額合計 | |  | | | | | | 不支給の理由 | |  | | | | | | **固定文言３**  備考 | | **固定文言４＋編集２** | | | | | | 振込口座 | 金融機関 |  | | | | | | 口座種目 |  | 口座番号 | |  | | | 口座名義人 |  | | | | | | 振込予定日 | |  | | | | | | **自由記載２** | | | | | | | | | |  | 窓口払 | お持ちいた  だくもの | ・  ・ | | 支払場所 | |  |  | | 支払期間 | |  | | 不服の申立て及び取消訴訟  この通知について不服があるときは、この通知を受け取った日の翌日から起算して３か月以内に、都道府県名 介護保険審査会（ 都道府県郵便番号　都道府県住所　電話：都道府県電話番号 ）に対し審査請求をすることができます。（なお、通知を受け取った日の翌日から起算して３か月以内であっても、この処分の日の翌日から起算して１年を経過すると、審査請求することができなくなります。）  この処分の取消しを求める訴えは、前述の審査請求に対する裁決の通知を受けた日の翌日から起算して６か月以内に、 市町村名１ を被告として（訴訟において 市町村名２ を代表する者は 市町村長 となります。）提起することができます。  ただし、次の１から３のいずれかに該当するときは、審査請求に対する裁決を経ないで処分の取消しの訴えを提起することができます。  １　審査請求があった日から３か月を経過しても裁決がないとき。  ２　処分、処分の執行又は手続の続行により生ずる著しい損害を避けるため緊急の必要があるとき。  ３　その他裁決を経ないことにつき正当な理由があるとき。 | | | | | | | | |   **不服の申立て及び取消訴訟** | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **高額介護予防サービス費相当事業費**  **サービス提供年月別明細** | | | | | | | | |  | 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５**  備考 |  | |  |  |  |  |  | **固定文言６＋編集３** | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |