高額医療合算介護(予防)サービス費支給申請書兼自己負担額証明書交付申請書

様式番号

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| 申請対象年度 | 年度 | 申請区分 | 1.新規 | 2.変更 | 3.取下げ | （保険者等記入欄） | 支給申請書整理番号 |  |

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| フリガナ | | | |  | | | | | | | | | | | | | 生年月日 | | | | |  | | | | | | | | | | | | | | 個人番号 | | | | | | | | | | | | | | | |  | |  | |  |  | |  |  | |  |  |  | |  | |  |  | |
| 氏　　名 | | | |  | | | | | | | | | | | | | 計算期間の始期及び終期 | | | | | | | | | | | | | | | | 年　　　月 ～　　　　年　　　月 | | | | | | | | | | | | | | | | | | |
| 国民健康保険資格情報 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険者番号 | | | | | | 被保険者記号 | | | | 被保険者番号 | | | | | | | | | | | 続柄 | | | | | | | | 保険者名称 | | | | | | | | | | | | | | 加入期間 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | |  | | | | | | | | | | | １．世　帯　主  ２．擬制世帯主  ３．世　帯　員 | | | | | | | |  | | | | | | | | | | | | | | 年　　月　　日 から　　　 年　　月　　日 まで | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 後期高齢者医療資格情報 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険者番号 | | | | | | 被保険者番号 | | | | | | | | | | | | | | | 広域連合名称 | | | | | | | | | | | | | | | | | | | | | | | 加入期間 | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 介護保険資格情報 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険者番号 | | | | | | 被保険者番号 | | | | | | | | | | | | | | | 保険者名称 | | | | | | | | | | | | | | | | | | | | | | | 加入期間 | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 支給方法 | | | 口座管理  番号 | | | 振込口座  記入欄 | 銀行  信用金庫  農協  (　　　　) | | | | 金融機関コード | | | | | | | | 本　店  支　店  (　　　) | | | | | | | | 店舗番号 | | | | | 種目 | | | | | | 口座番号 | | | | | | | | | | | | | | | フリガナ | | | | |  | | | | | | | | | 振込先口座管理番号 | | | |
| １.窓口払い  ２.口座振込 | | |  | | |  |  | |  | |  | | |  | | |  |  | １．普通預金  ２．当座預金  ９．そ の 他  () | | | | | |  |  | |  | | | |  |  | | |  | |  | | 口座名義人 | | | | |  | | | | | | | | |  | | | |
| ゆうちょ銀行 | | | | 記号 | |  | |  | | |  | |  | | |  | |  | | | 番号 | | |  | |  | |  | |  | |  | | |  | | | |  | | | |  | | |
| □　公金受取口座を利用します。 | | | | | | | | ※ 給付金等の受取口座として、国に事前に登録した公金受取口座を利用する場合は、「□　公金受取口座を利用します。」にチェック（✓）してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ※ 公金受取口座を利用する場合は、口座情報（上記太枠部）の記載や通帳の写しの添付等は不要です。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ | 高額医療合算介護(予防)サービス費の支給申請簡素化を希望します。  今後、高額医療合算介護(予防)サービス費に該当した場合、支給申請は不要となります。（ただし、世帯構成などに変更があった場合はその限りではありません。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | 保険者名 | | | | | | 加入期間 | | | | | | | | | | | | | | | 添付の自己負担額証明書整理番号 | | | | | | | | | | | | | | 備考欄 | | | | | | | **固定文言１＋編集１** | | | | | | | | | | | | | | | | | | | | | | | |
| 保険者  加入歴 | | | １ | |  | | | | | | 年　　月　　日から  　　年　　月　　日まで | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| ２ | |  | | | | | | 年　　月　　日から  　　年　　月　　日まで | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| ３ | |  | | | | | | 年　　月　　日から  　　年　　月　　日まで | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
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| 〒  **固定文言２＋編集２** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ○○市（町村）長　様 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. 上の対象者について、高額医療合算介護（予防）サービス費の支給を申請します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 郵便番号　　　　　　住所 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. 上の対象者について、自己負担額証明書の交付を申請します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 申請代表者 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ※自己負担額証明書の交付申請を行う場合、①・②のいずれも丸で囲んでください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 氏名 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 高額医療合算介護（予防）サービス費の支給申請を行う場合、①のみを丸で囲んでください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **自由記載１** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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