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| **国民健康保険特定疾病認定申請書** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 被保険者記号・番号 | | | | | | **茅　・** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 認定対象者 | 氏　　名 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 生年月日 | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 |  | | |  | |  | |  | | |  | |  | | |  | | | |  | |  | | |  | |  | | |  | |
| 特定疾病名 | | | １　人工透析を実施している慢性腎不全  ２　血漿分画製剤を投与している先天性血液凝固第Ⅷ因子障害又は先天性血液凝固第　因子障害  ３　抗ウイルス剤を投与している後天性免疫不全症候群 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 上記診療開始日 | | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険医の意見 | 上記のとおり診療を受けていることに相違ありません。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 療養取扱機関の  所在地及び名称 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険医氏名　　　　　　　　　　　　　　　　　　　　　　　　　㊞ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 上記のとおり申請します。  　　　　年　　　　月　　　　日  （宛先）　茅野市長 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 世帯主 | | | | 住　　所 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | 氏　　名 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | 個人番号 | | | |  | |  |  | |  | |  | | |  |  | | |  | |  |  | |  | | |  | |  |
|  | | | | 電　　話 | | | | －　　　　　－ | | | | | | | | | | | | | | | | | | | | | | | | |
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| 処理欄 | 本　人　確　認 | | | | | | | | | | | | | | | 入力 | | | | 証発行交付 | | | | | | | | | 受付 | | | |
| 個人番号カード・免許証  旅券・在留カード・資格確認書・年金手帳  障害手帳通帳・診察券・その他（　　　　　） | | | | | | | | | | | | | | |  | | | | □　窓口 | | | | | | | | |  | | | |
| □　郵送　　 ／ | | | | | | | | |