様式第1号(第2条関係)

精神障がい者医療費受給資格認定申請書

　　年　　月　　日

　(宛先)三条市長

申請者(世帯主等)　住所

氏名

電話番号

　次のとおり申請します。

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| 医療を受ける方(受療者) | ふりがな | |  | | | | | | | | 生年月日 | | | | | | | | | | 年　　月　　日 | | | | | | | | | | |
| 氏名 | |  | | | | | | | |
| 住所 | | 電話 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 |  |  | |  | |  | | | |  | |  | |  | |  | | |  | |  | | |  | | |  | |
| 加入保険 | 被保険者氏名 |  | | | | | | | | | | | | | | | | | | | | | 付加給付の状況 | | | | | | | |
| 記号・番号 | 記号　　　　　　　　　　・　番号 | | | | | | | | | | | | | | | | | | | | | 有・無 | | | | | | | |
| 保険者名・番号 | 名称　　　　　　　　　　・　番号 | | | | | | | | | | | | | | | | | | | | | 保険給付割合 | | | | | | | |
| 所在地 |  | | | | | | | | | | | | | | | | | | | | | 割 | | | | | | | |
| 治療開始年月日等 | | 年　　月　　日 | | | | | | | | | | 医療機関名 | | | | | | | | |  | | | | | | | | | |
| 世帯主等(受給者) | ふりがな | |  | | | | | | | | | | 生年月日 | | | | | | | | | 年　　月　　日 | | | | | | | | | |
| 氏名 | |  | | | | | | | | | |
| 住所 | |  | | | | | | | | | | 受療者との続柄 | | | | | | | | |  | | | | | | | | | |
| 個人番号 |  |  | |  | |  | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | |
| 振込先 | 金融機関名 | 銀行・信金・信組・農協　　　　　　　　支店 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 預金種別 | 普通・当座 | | | 口座番号 | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 振込口座 | 受給者本人 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受療者の属する世帯の世帯主等（受給者）と同一の世帯全員 | | | 氏名 | | | 個人番号 | | | | | | | | | | | | | | | | | | | | | | | | | |
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| (注)　※添付書類　医師の診断書 | 受給者番号 |  |