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|  | | |  |  | | | |  | | | | | | | | | | | | | | | | |  | (国保法施行規則第27条14の２の様式) | | | | | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | |  | | | | | | | | | | | | | | | | |  | |  | | | | | 事務長 | | | | | | 確　認 | | | | | | 担　 当 | | | |
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| 国民健康保険　限度額適用・標準負担額減額　認定申請書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 記号･番号 | | | | | 医　　 　－ | | | | | | | | | | | | | | | | | | | | (准)組合員  氏名 | | | |  | | | | | | | | | | | | | | | | | | |
| （准）組合員  のマイナンバー | | | |  | |  | |  |  |  | | | |  |  |  | |  | |  |  |  |
| 認定対象者  氏　　　　　名 | | | | |  | | | | | | | | | | | | | | | | | | | | （准）組合員  と　の　続　柄 | | | |  | | | | | | | | | | | | | | | | | | |
| 認定対象者  のマイナンバー | | | | |  |  | | | |  | |  |  |  |  | |  |  | |  | |  |  | |
| 認定対象者  の生年月日 | | | | |  | | | | | | 昭・平　　年　　月　　日 | | | | | | | | | | | | | | | | |  | 年　齢 | | | | | | | 歳 | | | | | | | | | | | |
| 認定対象者  の住所 | | | | | 〒　　　　　－ | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| １．これから入院される期間についてご記入ください。（外来診療の場合は記入不要） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ① | | 入院予定期間 | | | | | | | | | | | | | | | | | 令和　年　月　日から | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| 令和　年　月　日まで | | | | | | | | | | | | | | | | | | 日間 | | | | | | | | | | |
| 入院をする保険医療機関等 | | | | | | | | | | | | | | | | | 名称 | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | |
| 所在地 | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | |
| ２．申請日の前１年間にご入院されたことがある場合ご記入ください。  　　（外来診療の場合は記入不要） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 入院をした保険医療機関の名称 | | | | | | | | | | | | | | | | | 申請日の前１年間の入院期間（日数） | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ① | |  | | | | | | | | | | | | | | | | | 令和　年　月　日から | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| 令和　年　月　日まで | | | | | | | | | | | | | | | | | | 日間 | | | | | | | | | | |
| ② | |  | | | | | | | | | | | | | | | | | 令和　年　月　日から | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| 令和　年　月　日まで | | | | | | | | | | | | | | | | | | 日間 | | | | | | | | | | |
| ③ | |  | | | | | | | | | | | | | | | | | 令和　年　月　日から | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| 令和　年　月　日まで | | | | | | | | | | | | | | | | | | 日間 | | | | | | | | | | |
|  | | 上記のとおり必要書類を添えて申請します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 京都府医師国民健康保険組合理事長　様 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 令和　　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | (准)組合員氏名 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
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| 組合記入欄 | 適用区分 | | | | | | | | ア・イ・ウ・エ・オ | | | | | | | | | | | | | | | 長期該当年月日 | | | | | |  | | | | | | | | | | | | | | | | | |
| 交付年月日 | | | | | | | |  | | | | | | | | | | | | | | | 回収年月日 | | | | | |  | | | | | | | | | | | | | | | | | |
| 発効年月日 | | | | | | | |  | | | | | | | | | | | | | | | 備考 | | | | | |  | | | | | | | | | | | | | | | | | |
| 有効期日 | | | | | | | |  | | | | | | | | | | | | | | |