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| 届書コード  届書 | | | 作成区分 |  |  | 作成区分 | ３：給付記録  　（支給記録）  ４：給付記録  　（承認記録） | **健康保険** | **被保険者**  **家　　族** | **移送費支給申請書**  *記入例* |
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| 社会保険委員  の点検済印 |
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| 送信  被　保　険　者　が　記　入　す　る　と　こ　ろ  ◎記入の方法は裏面に書いてありますからよく読んで下さい。  ◎「※」印欄は記入しないで下さい。 | | | 被保険者証の記号・番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ④生年月日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ⑤ | | | 被扶養  者番号 | | | | | | | | | | ⑥ | | 給付記  録番号 | | | | | | | ⑦ | | | | | 受　取  代理人 | | | | | |  | | | | ⑧受付年月日 | | | | | | | | | | | |
| ① | |  | | | ② | | |  | | |  | | | | ③ | | | |  | | | |  | | | | | |  | | | | | | | |  | | | | | | | | | | |  | | | | | | | | 3  5  7  9 | | | | | 大  昭  平  令 | | | | | | | | ３ | | | | | | 年  ２ | | | | ０ | | | 月  ２ | | | | | ０ | | | | | | | 日  ７ | | | | | ※ | | | | |  | | | | | | | | ※ | | |  | | | |  | | ※ | | | 0：無  1：有 | | | | | | | | ※ | | 年 | | |  | | 月 | |  | | 日 |
| ※ | |  | | | １ | | | ２ | | | ３ | | | |  | | | |  | | | |  | | | | | | ４ | | | | | | | | ５ | | | | | | | | | | | ６ | | | | | | | |
| ⑨被保険者の  （申請者）  氏名と印 | | | | | | | | | | | | | | | フリガナ　イチコウ　　タロウ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 事業所の | | | | | ㋐名　称 | | | | | | | | | | ×××××株式会社 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 市光　太郎　　　　　　　㊞ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ㋑所在地 | | | | | | | | | | 神奈川県伊勢原市○○番地 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ⑪被保険者の  （申請者）  住所 | | | | | | | | | | | | | | | ⑩ | 郵便  番号 | | | | | | | | | | | | | ２ | | | | | | | ５ | | | | | | | | | ９ | | | | | | | | １ | | | | | | | １ | | | | | | | | ２ | | | | | | ９ | | | | | フリガナ　　カナガワケンイセハラシ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | （電話番号） | | | | | | | | |
| 神奈川県伊勢原市○○番地 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ××××  （××）×××× | | | | | | | | |
| ⑪ | 住　所  コード | | | | | | | | | | | | | ※ | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | |  | | | | | | |
| 被扶養者が移送を受  けたときはその者の | | | | | | | | | | | | | | | | ㋒氏名 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ㋓生年月日 | | | | | | | | | 大正  昭和  平成  令和 | | | | 年　　　月　　　日 | | | | | | | | | | | | | | | | | | ㋔被保険者  との続柄 | | | | | | | | | | |  | | | | | | | | | | | | | | | |
|  | | ⑫傷病コード | | | | | | | | | | | ※ | | | |  | | |  | | | | |  | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | | | | |  | | | | | | | | |  | | | | | | | |  | | | | | | | |  | | |  | | | |  | | | |  | | | | | | | | ㋕  傷　病　名 | | | | | | | | | | | | | 脳出血 | | | | | | | | | | | | | | | | | | | | | | | | | ⑭発病又は負傷年月日  　（療養開始日） | | | | | | | | | | | | |
| ⑬カ　　　ナ | | | | | | | | | | | ※ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | １ | | 年  ７ | | | ０ | | 月  ５ | | ２ | | 日  ５ | |
| ㋖  発病又は負傷の  原因を詳しく | | | | | | | | | | | | | | | | | | 突然、気分が悪くなり倒れた | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ⑪　　第三者行為によるものですか | | | | | | | | | | | | | | | | | | | | | | | | | |
| 0：いいえ　　　1：は　い | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療等の支給又は手  当を受けた病院ある  いは診療所（医院）の | | | | | | | | | | | | | | | | | | | | | ㋗ 名　称 | | | | | | | | | | | | | | | | | | | | | | | | | | | 平塚病院 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ㋘ | | | 診療を担当した  医師等の氏名 | | | | | | | | | 鈴木　太郎 | | | | | | | | | | | | | | | | | | | | | | | | | |
| ㋙ 所在地 | | | | | | | | | | | | | | | | | | | | | | | | | | | 神奈川県平塚市××１－２－３ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 移送を受け  た区間、移  送期間およ  び費用の請求 | | | | | | | | | | | | | | | | | | ⑯区間 | | | | | | | フリガナ　　ヒラツカ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | フリガナ　　イセハラ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ⑰移送後 | | | | | 0：入院外　　1：入院 | | | | | | | | | | | | | | |
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| 平　塚　　　　　　　から | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 伊 勢 原　　　　　まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ㋚移送先 | | | | | 伊 勢 原　　　病 院 | | | | | | | | | | | | | | |
|  | | | | | | | ⑱　移　送　期　間（支給期間） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ㋛移送回数 | | | | | | | | | | ㋜移送に要した費用の額 | | | | | | | | | | | | | ㋝距離 | | | ㋞利用交通機関 | | | | | | | | | | | | | |
| 自 | | | | | | | １ | | | | | | | 年  ７ | | | | | | | | | ０ | | | | | | | | | | 月  ５ | | | | | | | ２ | | | | | | | | | 日  ５ | | | | | | | | | | 至 | | | | |  | | | | | 年 | | | | | |  | | | | | | 月 | | |  | | | | 日 | | | 回 | | | | | | | | | | 円 | | | | | | | | | | | | | ｋｍ | | |  | | | | | | | | | | | | | |
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| ※ | | ⑲ | | 支給  回数 | | | | | ⑳承認番号 | | | | | | | | | | | | | | | | | | 支給算出額 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 調整減  額コード | | | | | | | | | | | | | | | 調査先  コード | | | | | | | | | | | | | 海　　外  表示 | | | | | | | | | | 特別支  給コード | | | | | | | | |  | | |
|  | | | | 回 | | |  | | |  | | |  | | | | |  | | | | | | |  | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | |  | | | | | | | |  | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | 0：国内  1：海外 | | | | | | | | | |  | | | | | | | | |  | | |
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| 支払金融機関の欄  伊勢原 | 支払区分 | | | | | | | | | | | | | | | | | | | | ※  1：振　　　込  2：銀行送金  3：郵便局送金  4：当　地　払 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 預金種別 | | | | | | | | | | 1：普　通  2：当　座  3：通　知  4：別　段 | | | | | | | | | | | | | | | | | | | | | | | ㋟ 銀　行  市光  信用金庫  農　協 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 本店  支店 | | | | | | | | | | | | | | | | | | |
|  | | | | | | 金融機関  コード | | | | | | | | | | | | | | ※  × | | | × | | | | | | × | | | | | | | × | | | | | | | | | × | | | | | | | | | × | | | | | | | × | | | | | | | | 口座名義 | | | | | | | | | | | 市光　太郎 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 口座番号 | | | | | | | | | | | | | | | | | | | | × | | | × | | | | | | × | | | | | | | × | | | | | | | | | × | | | | | | | | | × | | | | | | | × | | | | | | | | × | | | | | | × | | | | | | | × | | | | × | | | | × | | | | | | | | × | | | | 郵便局 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| 受取代理人の欄  送信 | ㋠　　　本請求に基づく給付金に関する受領を代理人に委任します。  令和　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 令和　　年　　月　　日提出  受付日付印 | | | | | | | | | | | | | | | | | |
| 被保険者  （申請者） | | | | | | | | | | | | | | | 住所  氏名 ㊞ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 代理人の  氏名と印 | | | | | | | | | | | | | | | | | | | | フリガナ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ㋡委任者と代理人との関係 | | | | | | | | | | | | | | | | | | | | | | |
| ㊞ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| 代理人  の住所 | | | | | | | | | 郵便番号 | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | |  | | | | | | |  | | | | | |  | | | | | |  | | | | | | |  | | | | | | フリガナ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所コード | | | | | | | | | | | | | | | | | | | ※ | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | |
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| 社会保険労  務士の提出  代行者印 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ㊞ | | | | | | | | | |  | | | | | | | | | | | | | | | | | |

（記入上の注意）

1．この申請書は、被保険者及び被扶養者について移送の承認があった場合にその費用の支給を受けるため申請するものです。

2．この申請書には、移送に要した費用の領収書を必ず添付して下さい。

3．標題の「被保険者」・「家族」の文字は、いずれか該当する方をマルで囲んで下さい。

4．標題の「被保険者」の文字をマルで囲んだときは、㋒、欄に「該当せず」と記入して下さい。

5．④、⑮、⑰およびの欄は、該当する番号をマルで囲んで下さい。

6．⑨の欄は、被保険者が自ら署名する場合には、押印は不要です。

7．傷病の原因が第三者行為によるものであるときは、別に「第三者行為による傷病届」をこの書類に添付して下さい。

8．給付金の受領方を他人に委任するときは、受取代理人の欄に必要事項を記入し、支払金融機関の欄に受取代理人名義の口座を記入して下さい。

9．証明書等が外国語で記載されている場合は、翻訳者の住所・氏名を明記した翻訳文を添付して下さい。