Request to Attending Physician or Superintendent of Hospital/Clinic

1. Please fill in this form so that the patient may claim the National Health Insurance benefit.
2. This form should be completed and signed by either the attending physician or the superintendent of hospital/clinic.
3. One form for each month and one form for hospitalization/outpatient (home visit)should be filled out.
4. If not in dollars, please specify the unit used.

Itemized Receipt
領 収 明 細 書

Form B

1. Fee for Initial Office Visit	初 診 料	$
2. Fee for Follow -up Office Visit	再 診 料	$
3. Fee for Home Visit	往 診 料	$
4. Fee for Hospital Visit	入院管理料	$
5. Hospitalization	入 院 費	$
6 .Consultation	診 察 費	$
7. Operation	手 術 費	$
8. Professional Nursing	職業看護婦費	$
9. X- Ray Examinations	X線検査費	$
10. Laboratory Tests	諸検査費	$
11. Medicines	医 薬 費	$
12. Surgical Dressing	包 帯 費	$
13. Anesthetics	麻 酔 費	$
14. Operating Room Charge	手術室費用	$
15. Others(Specify)	その他(項目明記)	$
		$
		$
16. Total	合計 $	貨幣単位 Unit is

Important: Exclude the amount irrelevant to the treatment i.e. payment for a luxurious room charge.
高級室料等治療に直接関係のないものを除いてください。

Name and Address of Attending Physician/Superintendent of Hospital or Clinic

Name 名前 : Last 姓 First 名 Title 称号

Address 住所 :Home 自宅 Phone 電話
Office 病院 Phone 電話

Date 日付 : Signature 署名