**被保険者**

**家　　族**

**健康保険　　　　　移送費支給申請書**

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| 事業所担当者印 | |  | | 被　　保　　険　　者　　が　　記　　入　　す　　る　　と　　こ　　ろ | 被保険者証の | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ③　生　年　月　日 | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | | ①記号 | | | | | ②番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | 昭和  平成 | | | | | |  | | 年 | | |  | | | 月 | |  | | 日 | | |  | | | | | | | | | | | | | | | | |
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|  | | 被保険者の  氏名と印 | | | | | | | | | (フリガナ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 事業所の | | | 名称 | | | | | |  | | | | | | | | | | | | | | | | | | |
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|  | | 所在地 | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | 被保険者の  住所 | | | | | | | | | 郵便番号 | | | | | | | | | ― | | | | | | | | | | | | | | | (フリガナ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | (電話番号) | | | | | | | |
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|  | | 扶養が被扶養者の関する  ときは、その方の | | | | | | | | | | | | | | | ④氏名 | | | | | | |  | | | | | | | | | | | | | | | | | | | | ⑤生年  月日 | | | | | 昭和  平成  令和 | | | | | 年　　月　　日生 | | | | ⑥被保険者  との続柄 | | | | | | | | |  | | | | |
|  | | 傷病名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 発病または負傷年月日  (療養開始日) | | | | | | | | | | |
|  | |  | | 年 | | |  | | 月 |  | 日 | |
|  | | 発病または負傷の  原因を詳しく | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 第三者行為によるものですか | | | | | | | | | |
|  | | いいえ　・　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 | | | | | | | | | | | | | | | 名称 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | 診療を担当した  医師等の氏名 | | | | | |  | | | | | | | | | | | | | | |
|  | | 所在地 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 移送を受けた区間、  移送期間および費用  の請求 | | | 区間 | | | | (フリガナ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | (フリガナ) | | | | | | | | | | | | | | | | | | 移送後 | | | | 入院　・　入院外 | | | | | | | | | | | |
|  | | から | | | | | | | | | | | | | | | | | | | | | | | | | | | | | まで | | | | | | | | | | | | | | | | | |
|  | | 移送先 | | | | 病院 | | | | | | | | | | | |
|  | | 移送期間 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 移送回数 | | | | | | | 移送に要した費用の額 | | | | | | 距離 | | | | | | 利用交通機関 | | | | | | |
|  | | 自 | | | |  | | | | 年 | | |  | | | 月 | | |  | | | 日 | | | 至 | | |  | | 年 | | |  | | | 月 | |  | | 日 | | | 回 | | | | | | | 円 | | | | | | ㎞ | | | | | |  | | | | | | |
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|  | |  | | | | | | 支　　給　　金　　額 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 法定給付 | | | | | |  | | | |  | | | |  | | | |  | | | | |  | | | |  | | |  | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 付加給付 | | | | | |  | | | |  | | | |  | | | |  | | | | |  | | | |  | | |  | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 合計 | | | | | |  | | | |  | | | |  | | | |  | | | | |  | | | |  | | |  | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | 承認番号 | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | 常務理事 | | | | 事務長 | | | | | | | | 係 | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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