# 支　出　計　算　書

| 伝票番号 | 1 | 2 | 3 | 4 | 小切手番号 | |
|---|---|---|---|---|---|---|

| 支部長 | 理　事 | G　L | 副GL | 主査 | グループ員 |
|---|---|---|---|---|---|
| | | | | | |

Leave this block blank.

令和 5 6 年 7 8 月 9 10 日

氏名　　　　　　　　印

| ※ 決裁年月日 | ※ 決定額 | | 療養費・家族療養費 | 高額療養費 |
|---|---|---|---|---|
| | | 法定給付 | 25　31 円 | 39　45 円 |
| | | 附加給付 | 32　38 円 | 合計 |
| | | 計 | 円 | 円 |

Circle the one that applies. (If you do not know which one to choose, skip this field).

| データ区分※ | | | |
|---|---|---|---|
| 11 | 12 | 13 | 14 |
| 3 | 0 | | |

Medical Treatment Expenses
Partial Copayment Reimbursement Benefit
Family Medical Care Supplementary Benefit
High-Cost Medical Treatment Benefit

Request for Payment

24

| Membership Card Number | | Date of First Medical Examination | 平成 令和　年　月　日 |
|---|---|---|---|
| Name of Member | | Name of Disease/Injury | |
| Name of Medical Care Recipient | 本人:1 家族:2 (23) | Cause of Disease/Injury | |
| Date of Birth of Medical Care Recipient | 明・大 昭・平　年　月　日 (Relationship) | Period of Medical Treatment | 令和　年　月　日から 令和　年　月　日まで (46) (47) 日間 |
| Expenses for Medical Treatment | 円 | Name and Address of Medical Institution or Pharmacy | |

| 請求額 | | 療　養　費 | 高　額　療　養　費 |
|---|---|---|---|
| | 法定給付等 | 円 | 円 |
| | 附加給付等 | 円 | 合　計 |
| | 計 | 円 | 円 |

Leave this block blank

| ※ 医療機 (48) | 保険医療機関 保険薬局 他 | ※ 所在区分 (49) |
|---|---|---|

Leave this block blank

| Reason for not using Membership Card | As specified on the reverse side of this form |
|---|---|
| 過去の高額療養費の支給状況等 | Leave this block blank |

I hereby claim payment of benefits as above.
上記のとおり請求します。

To the Branch Manager,MEXT Mutual Aid Association, Hiroshima
文部科学省共済組合広島大学支部長　殿

Year　Month　Day
令和　　年　　月　　日

Claimant
所属部(室)グループ名
Address
Name

※Please read carefully the instructions on the reverse side before completing this form.

| 部局受付年月日 | 受付者 |
|---|---|
| | |

Reason

Instructions

1. Provide full details of why you or your dependent did not use your or his/her membership card.
2. If the total monthly copayment amount that the member or his/her dependent pays for services (excluding meals and living care during hospitalization) provided by the same hospital, clinic, pharmacy or other healthcare organization, or for home-visit nursing care services provided by the same qualified home-visit care organization (in the case of services that the patient received before the month when he/she reaches the age of 70, only copayments of 21,000 yen or more are qualified for this benefit) is higher than the specified amount (copayment cap), the amount exceeding the upper limit will be paid by the Association as a high-cost medical treatment benefit. A Request for Payment form should be prepared for each event (for each monthly invoice issued for a patient by a healthcare organization), leaving the "Amount Claimed" block blank. When filing payment request forms for two or more billing statements, submit them along with a document that indicates the total amount of benefits to be claimed.
3. If you paid the "amount still to be borne by patient" used as a basis for the calculation of the high-cost medical treatment benefit to be paid in pursuant to the provisions of Article 11.3.4, paragraphs (1)-(3) of the National Public Service Personnel Mutual Aid Association Law Enforcement Ordinance, enter the amount in the "Expenses for Medical Treatment" field separately from other medical expenses, and attach supporting evidence to this form.
4. If you have received high-cost medical treatment benefits for three months or longer during the one-year period prior to the month in which the patient(s) receive(s) medical treatment for which you are filing this request for payment, specify the months and amounts in the "Payment status etc. of high-cost medical treatment benefits in the past" field.
5. If you fall under the category of beneficiaries stipulated in Article 11.3.5, paragraph (1), item (iii) of the National Public Service Personnel Mutual Aid Association Law Enforcement Ordinance, attach supporting evidence to this form.
6. Leave the fields marked with "※" blank.
7. In field No. 13, specify the type of healthcare service by entering the corresponding number: Inpatient care: 1; Outpatient care: 2; Inpatient dental care: 3; Outpatient dental care: 4; Pharmacy: 5.