1.This form is used for claiming the social insurance benefit.
2.This form should be completed and signed by the attending physician.

ATTENDING PHYSICIAN'S STATEMENT
(海外) 診 療 内 容 明 細 書

Name of Patient (患者名)		Date of Birth (生年月日)	Sex (性別) Male　　Female
Date of First Diagnosis (初診日) ,20	Days of Diagnosis days.	Diagnosis/Symptoms (診断／症状)	
Type of Treatment (治療の分類) ☐ Hospitalization (入院)　☐ Outpatient or Home Visit (入院外)		From ,20 To ,20	(days)

Description of Service (診療内容)	Fee (料金)
1. Consultation (診療)	
2. Medication (投薬)	
3. Injection (注射) ☐ Injection (注射)　☐ IV Treatment (点滴)	
4. Laboratory (検査)	
5. Hospitalization (入院)	
6. Operation (手術)	
7. Radiology (画像診断) ☐ X-ray (レントゲン)　☐ Ultrasound (超音波)　☐ Nuclear Scan (核医学診断)	
8. Anesthesia (麻酔) ☐ Local (局部)　☐ Spinal(脊髄)　☐ General(全身)	
9. Others (Specify) その他(項目明記)	
Total Fee 合　計	

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

Name:

Address:

Date:　　　　　　　　　　Signiture: