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| 高齢者の医療の確保に関する法律　　　　　　　　　　　　　　　　　　　　年　　　月　　　日  **一部負担金相当額支給申請書**  金　額　　　　　　　　　　　　　　円  上記の金額の支給を申請いたします。   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 後期高齢者医療被保険者証 | 保険者番号 | ３ | ９ | ２ | ７ |  |  |  |  | | 被保険者番号 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 被爆者健康手帳 | 公費負担者番号 | 1 | ９ | ２ | ７ | 6 | 0 | 1 | 3 | | 公費負担医療の  受給者番号 |  |  |  |  |  |  |  |  | | 交付年月日 | 年　　月　　日 | | | | | | |  |   居   |  |  |  |  | | --- | --- | --- | --- | | 郵便番号 |  |  |  | | 居住地 |  |  |  | | 氏　　名 | ㊞ | | | | 生年月日 | Ｍ・Ｔ・Ｓ　　　　年　　　月　　　日生 | | | | 電話 | 市外局番　　　 市内局番　　 　番　　号  (自　宅)  (携　帯)  (呼　出)    ―　　　　　　― | | |     大阪府知事様  ㊿  ※被爆者一般疾病医療機関から医療を受けることができなかった理由  **（**１一般疾病医療機関以外　２現物給付の対象外　３その他　　　　　　　　　**）**  一部負担金  の割合  （　　　割） |
| 支払希望機関   |  |  | | --- | --- | | 銀行・信用金庫 | 普通預金口座番号 | | 支　店 |  | |