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| 自立支援医療受給者証等記載事項変更届出書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 受診者 | | フリガナ |  | | | | | | | | | | | | | | 性別 | | | | | | | 生年月日 | | | | | | | | | | | | |  |
| 氏名 |  | | | | | | | | | | | | | | 男・女 | | | | | | | 年　　月　　日 | | | | | | | | | | | | |
| フリガナ |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 |  | |  | |  | | |  | | | |  | | | |  | | |  | | | |  | | | |  | |  | |  | |  | |
| 保護者(受診者が18歳未満の場合記入) | | | フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | 続柄 | | | | | | |
| 氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 | | | | |  | | |  | |  | | |  | | | |  | | |  | | |  | |  | |  | |  | |  | |  |  | |
| 自立支援医療費受給者番号 | | |  |  | |  | | |  | | |  | | |  | | | |  | | |  | | | | |  | | | | | | | | | |  |
| 受給者証の有効期間 | | | 年　　月　　日　から　　　年　　月　　日　　まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 変更内容 | 事項 | | 変更前 | | | | | | | | | | | | | | | | | | 変更後 | | | | | | | | | | | | | | | |
| 受診者に関する事項  (氏名・住所・電話番号) | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 保護者に関する事項  (氏名・住所・電話番号) | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 被保険者証に関する事項  (記号及び番号・保険者名・受診者と同一の加入者) | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 身体障害者手帳・精神障害者保健福祉手帳番号 | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 備考 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 自立支援医療受給者証及び自立支援医療支給認定申請書に記載された事項の変更について上記のとおり届け出ます。  届出者氏名　　　　　　　　　　印  　　　　　　　　年　　月　　日  田村市福祉事務所長　様 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ※　自己負担上限額(所得区分及び重度かつ継続該当・非該当)及び指定自立支援医療機関の変更については、支給認定の変更を行うため、自立支援医療費(育成医療・更生医療)支給認定(変更認定)申請書兼利用者負担額減額・免除申請書に記載すること。※　医療受給者証を添付してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |