介護予防支援委託料請求書

**請求日　令和　　 年　　 月　 　日**

**村 上 市 長　 様**

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| **請　求　事　業　者** |
| **所　在　地****名　　　称****代表者職氏名****電話番号** | **㊞** |
| **事業所番号** |  |  |  |  |  |  |  |  |  |  |

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| **令和　　年　　月分** |
| **被　保　険　者　番　号** | **初回加算** | **委託****連携加算** |
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**※　被保険者が８名以上の場合は「別紙のとおり」とし、別紙に記入してください。**

**※　初回加算・委託連携加算がある場合は、それぞれ□にチェックを入れてください。**

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| **請求内容** | **介護予防支援費** |  | **件** | **4,420円** | **金額** |  |  |  |  |  |  | **円** |
| **初回加算** |  | **件** | **3,000円** | **金額** |  |  |  |  |  |  | **円** |
| **委託連携加算** |  | **件** | **3,000円** | **金額** |  |  |  |  |  |  | **円** |
| **請求金額（合計）** |  |  |  |  |  |  | **円** |

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| **口　座　振　替　依　頼　書** |
| **金融機関名** |  | **支店名** |  |
| **口座の種別** | **1普通　 2当座　 3（ 　　　）** | **口座番号** |  |  |  |  |  |  |  |
| **（カタカナ）****口座名義** |  |
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**【介護予防支援委託料請求書・別紙】**

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| **令和　　年　　月分** |
| **被　保　険　者　番　号** | **初回加算** | **委託****連携加算** |
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