第6号様式(第5条関係)

支給認定申請内容変更届出書(精神通院医療)

記

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| 受診者 | フリガナ |  | | | | | | | | | | | | | | | | | | | | | 生年月日 | | | | | | | | | | | | |
| 氏名 |  | | | | | | | | | | | | | | | | | | | | | 年　　月　　日 | | | | | | | | | | | | |
| フリガナ |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 |  | |  | |  | | |  | | | |  | | |  | | | |  | | | |  | | |  | | |  | |  | |  | |
| 保護者(受診者が18歳未満の場合に記入してください。) | | 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 | | | | | | | | | | | | | | | |
| 受診者の氏名、住所又は電話番号 |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 保護者の氏名、住所又は電話番号 |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 被保険者証の記号及び番号、保険者名又は受診者と同一の保険に加入する者の名前 |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 身体障害者手帳又は精神障害者保健福祉手帳の番号 |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 備考 | | ●医療保険資格情報確認　□済 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 上記のとおり支給認定の申請内容を変更したので、障害者の日常生活及び社会生活を総合的に支援するための法律施行令第32条第1項の規定により、届け出ます。  　　　　　　年　　月　　日  届出者氏名  　新潟県知事　　　　様 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |