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| **自立支援医療受給者証等記載事項変更届（ 精神通院 ）** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受　　診　　者 | フリガナ | |  | | | | | | | | | | | | | | | | | | 性別 | | | | | | | | | | 生　年　月　日 | | | | | | | | | | | |
| 氏　　　名 | |  | | | | | | | | | | | | | | | | | | 男 ・ 女 | | | | | | | | | 大 正 | | | | 年　　月　　日 | | | | | | | | |
| 昭 和 | | | |
| 平 成 | | | |
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| 住　　　所 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 | |  | |  | | |  | | | |  | | | |  | | | |  | | | | |  | | | |  | | | |  | | |  | |  | | |  | |
| 保　護　者  （受診者が１８歳未満の場合のみ記入） | | | フリガナ | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | 続　　　柄 | | | | | | | | |
| 氏　名 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| 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 | | | 平成　　 年　　 月　　 日　から　平成　　 年　 月　　 日　まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 事　項 | | 変　更　前 | | | | | | | | | | | | | | | | | | | | | 変　更　後 | | | | | | | | | | | | | | | | | | |
| 変更内容 | 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） | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| 備　　　考 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 私は、自立支援医療受給者証（精神通院）及び自立支援医療費（精神通院）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 | | | | | | |  | | | | |  | | | |
| 平成　　　年　　　月　　　日 | | | | | | | | |  | | 白浜町長　様 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ※ | | 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（精神通院）支給認定申請書（変更）に記載すること。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |