自立支援医療受給者証等記載事項変更届(育成医療)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 受診者 | フリガナ |  | | | | | | | | | | | | | | | | | | | | | | | | 生年月日 | | | | | | | | | | | |
| 氏名 |  | | | | | | | | | | | | | | | | | | | | | | | | 年　　月　　日 | | | | | | | | | | | |
| フリガナ |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| １月１日現在居住していた区市町村（長岡市以外の場合のみ記入） | | | | | | | | | | | | | | | | | | | | | 都 道　　　　　　区 市  府 県　　　　　　町 村 | | | | | | | | | | | | | | | |
| 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 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| １月１日現在区市町村  （長岡市以外の場合のみ記入） | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| 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 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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。  　　　　　年　　月　　日  届出者氏名  　長岡市長　　　　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、自立支援医療支給認定申請書(変更)に記載すること。