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| 様式第27号 | | |  | | |  | | |  | | | | | | |  | | | | | | | |  | | | | | | | |  | | | | | | |  | | | | | |  | | | | |  |
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| 自立支援医療受給者証等記載事項変更届（ 育成医療 ・ 更生医療 ） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 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） | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  |
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| 保護者に関する事項　　　　（氏名・住所・電話番号） | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  |
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| 加入医療保険に関する事項　　（記号及び番号・保険者名・受診者と同一の加入者） | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | |  |
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| 身体障害者手帳・精神障 害者保健福祉手帳番号 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  |
| 備　考 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 私は、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。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | | 届出者氏名 | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | | | | 年 月 日 | | | | | | | | 土佐清水市福祉事務所長　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、自立支援医療支給認定申請書（変更）に記載すること。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |