**様式第四の二**（附則第二条関係）

サービス提供証明書

（介護老人保健施設における介護予防短期入所療養介護）

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| 公費負担者番号 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  | 年 |  |  | 月分 | |
| 公費受給者番号 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 被保険者 | 被保険者  番号 |  | | |  | | |  | | |  | | |  | | | |  | |  | | |  | |  | |  | |  | 請求事業者 | 事業所  番号 |  | |  | | |  | | |  | | |  | |  |  |  |  |  |
| (ﾌﾘｶﾞﾅ)  氏名 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | 事業所  名称 |  | | | | | | | | | | | | | | | | | |
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| 生年月日 | 1.明治　2.大正　3.昭和 | | | | | | | | | | | | | | | | | 性別 | | | 1．男　2．女 | | | | | | |  | | | | | | | | | | | | | | | | | |
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| 要支援  状態区分 | 要支援１・要支援2 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 認定有効  期間 |  | |  | | |  | | | 年 | | |  | | |  | | | 月 | |  | | |  | | 日 | | から | 連絡先 | 電話番号 | | | | | | | | | | | | | | | | | |
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| 介護予防  サービス  計画 | ２.被保険者自己作成　３. 介護予防支援事業者作成 | | | | | | | | | | |  | 入所年月日 |  |  |  | 年 |  |  | 月 |  |  | | | 日 |
| 事業所番号 |  |  |  |  |  |  |  |  |  |  |  | 退所年月日 |  |  |  | 年 |  |  | 月 |  |  | | | 日 |
| 事業所名称 |  | | | | | | | | | |  | 短期入所　実日数 | | | | | | | | | |  |  | |

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| 給付費明細欄 | サービス内容 | サービスコード | | | | | | 単位数 | | | | 回数  日数 | | サービス単位数 | | | | | 公費分  回数等 | | 公費対象単位数 | | | | | 摘要 |
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| 合計 | | | | | | | | | | | | |  |  |  |  |  |  | |  |  |  |  |  |  |

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| 緊急時施設療養費 | 緊急時  傷病名 | | | | ①  ②  ③ | | | | | | | | | 緊急時治療  開始年月日 | | | | | ①  ②  ③ | |  |  | | 年  年年 |  |  | 月  月  月 |  |  | 日  日  日 |
| 緊急時治療管理（再掲） | | | | | |  | 単位 |  | 単位× |  |  | | | 日 |  | | | | | | | | | | | | | | |
| 特定治療 | ﾘﾊﾋﾞﾘﾃｰｼｮﾝ | | | | |  | 点 | 摘要 | | | | | | | | | | | | | | | | | | | | | |
| 処置 | | | | |  | 点 |
| 手術 | | | | |  | 点 |
| 麻酔 | | | | |  | 点 |
| 放射線治療 | | | | |  | 点 |
| 合計 | | | | |  | 点 |
| 往診日数 | | |  |  | | 医療  機関名 | |  | | | | | 通院日数 | | | |  |  | | 医療  機関名 | | |  | | | | | | | | |

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| 特別療養費 | 傷病名 | |  | | | | | | | | | | | | | | | | | | | |
| 識別番号 | | 内容 | 単位数 | | | | 回数 | | 保険分単位数 | | | | | 公費回数 | | 公費分単位数 | | | | | 摘要 |
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| 請求額集計欄 | 区分 | 保険分 | | | | | | | 公費分 | | | | | | 保険分特定治療・特別療養費 | | | | | | 公費分特定治療・特別療養費 | | | | | |
| ①計画単位数 |  |  |  | |  |  |  |  | | | | | |  | | | | | |  | | | | | |
| ②限度額管理対象単位数 |  |  |  | |  |  |  |  | | | | | |  | | | | | |  | | | | | |
| ③限度額管理対象外単位数 |  |  |  | |  |  |  |  | | | | | |  | | | | | |  | | | | | |
| ④給付点数・単位数 |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑤点数・単位数単価 |  |  |  |  | | 円／単位 | |  | | | | | | 10円／点・単位 | | | | | | 10円／点・単位 | | | | | |
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| ⑦請求額（円） |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑧利用者負担額（円） |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| 特定入所者  介護予防サービス費 | サービス内容 | サービスコード | | | | | | 費用単価(円) | | | | 負担限度額 | | | | 日数 | | 費用額(円) | | | | | | 保険分 | | | | | | 公費日数 | 公費分 | 利用者負担額 | | | | |
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| 合計 | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  | | | | | |  |  |  |  |  |
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