様式第25号（第23条関係）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 自立支援医療受給者証等記載事項変更届（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） |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| 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。  　　　　　　　届出者氏名  　　　　　　　　　　　　　　　　年　　　　月　　　　日　　　　　岩国市福祉事務所長　様 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |