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| 自立支援医療受給者証（精神通院医療）等記載事項変更届 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受　　診　　者 | フリガナ |  | | | | | | | | | | | | | | | | | | | | | | 生年月日 | | | | | | | | | | |
| 氏　　　名 |  | | | | | | | | | | | | | | | | | | | | | | 年　 月　 日 | | | | | | | | | | |
| フリガナ |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住　　　所 | 〒　　　　　　　　　　　　　電話 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | 〒　　　　　　　電話 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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） |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 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（精神通院医療）及び自立支援医療費（精神通院医療）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  群馬県知事　あて | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

　※　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（精神通院医療）支給認定申請書（変更）に記載すること。