第19号様式（第12条関係）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 自立支援医療受給者証等記載事項変更届出書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受診者 | フリガナ |  | | | | | | | | | | | | | | | | | | | | | | 生年月日 | | | | | | | | | | | |
| 氏名 |  | | | | | | | | | | | | | | | | | | | | | | 年　　月　　日 | | | | | | | | | | | |
| 個人番号 |  | |  | |  | |  | | |  | | |  | | |  | | |  | |  | | |  | |  | |  | | |  | | | |
| フリガナ |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保護者(受診者が18歳未満の場合記入) | | フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | 続柄 | | | | |
| 氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| 個人番号 | | | | |  | | |  | | |  | | |  | | |  | | |  | | | |  | |  | |  | | |  |  |  |
| フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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  (記号および番号・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、自立支援医療支給認定申請書および自立支援医療受給者証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　　　　　練馬区長　　　　　殿 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

※　自己負担上限額(所得区分および重度かつ継続該当・非該当)およ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、自立支援医療費支給認定申請書(変更)に記載すること。