様式第24号(第20条関係)

医療受給者証（更生医療・育成医療）再交付申請書

　琴浦町長　様

　次のとおり医療受給者証の再交付を申請します。

申請年月日　　　　　年　　月　　日

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 受診者 | フリガナ | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏名 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 生年月日 | | | 年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 | | |  | | |  | | |  | | |  | | | |  | | |  | | | |  | | |  | | |  | |  | |  |  |
| フリガナ | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所 | | | 電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保護者(受診者が18歳未満の場合記入) | | フリガナ |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 続柄 | | |
| 氏名 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| 個人番号 |  | |  | | |  | | |  | | |  | |  | | |  | | |  | | |  | | |  |  | |  | |
| フリガナ |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所 | 電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 自立支援医療費受給者番号 | | | |  | |  | | |  | | |  | | |  | | |  | | |  | |  | | |  | | | | | | | | | |
| 医療受給者証の有効期間 | | | | 年　　月　　日から　　　　年　　月　　日まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申請の理由 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

　　注　1　医療受給者証を破り、又は汚した場合の申請については、現在お持ちの医療受給者証を添付してください。

　　　　2　再交付を受けた後、失った医療受給者証を発見したときは、速やかに町に返還してください。