様式第11号（第９条関係）

|  |  |
| --- | --- |
|  | 受付機関名 |
| 受付年月日　　　　年　　月　　日 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 自立支援医療受給者証再交付申請書（精神通院医療） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | |  | |  | | |  | | |  | | |  | | |  | |  | | |  | |  | | |  | |  | |  |
| 再交付が必要な理由 | | １　紛失　　２　汚れ　　３　破れ　　４　その他（　　　　　　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 精神障害者保健福祉手帳番号 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 備考 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 私は、上記のとおり、自立支援医療受給者証（精神通院医療）の再交付を申請します。  　　　　　　　　年　　　月　　　日  申請者氏名　　　　　　　　　　　　印  　（宛先）  　　滋賀県知事 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

注　太枠内の該当する項目のみ記載してください。