**様式第二**（附則第二条関係）

**記載例**

居宅サービス・地域密着型サービス介護給付費明細書

（訪問介護・訪問入浴介護・訪問看護・訪問リハ・居宅療養管理指導・通所介護・通所リハ・福祉用具貸与・定期巡回・随時対応型訪問介護看護・夜間対応型訪問

介護・地域密着型通所介護・認知症対応型通所介護・小規模多機能型居宅介護（短期利用以外）・小規模多機能型居宅介護（短期利用）・複合型サービス（看護小規模多

機能型居宅介護・短期利用以外）・複合型サービス（看護小規模多機能型居宅介護・短期利用））

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| 公費負担者番号 |  |  | 要介護の場合：様式第二要支援の場合：様式第二の二を必ずご使用ください。 |  |  |  |  |  |  |  |  |  |  |  |  |  | 令和 | 0 | 4 | 年 | 0 | 4 | 月分 |
| 公費受給者番号 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 被保険者 | 被保険者番号 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |  | 請求事業者 | 事業所番号 | 2 | 4 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (ﾌﾘｶﾞﾅ)氏名 | カイゴ　イチロウ | 事業所名称 | ○○医院 |
| 介護　一郎 |
| 所在地 | 〒 | 9 | 9 | 9 | － | 9 | 9 | 9 | 9 |  |
| 生年月日 | 1.明治　2.大正　3.昭和 | 性別 | 1．男　2．女 | ○○県○○市○○町9-9 |
| 1 | 6 | 年 | 0 | 3 | 月 | 3 | 1 | 日 |
| 要介護状態区分 | 要介護1・2・3・4・5 |
| 認定有効期間 | 1. 平成2.令和 | 0 | 3 | 年 | 0 | 4 | 月 | 0 | 1 | 日 | から | 連絡先 | 電話番号　059-999-9999 |
| 令和 | 0 | 5 | 年 | 0 | 3 | 月 | 3 | 1 | 日 | まで |

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| 居宅サービス計画 | １．居宅介護支援事業者作成　　　　　　２．被保険者自己作成　　　　 |
| 事業所番号 |  |  |  |  |  |  |  |  |  |  | 事業所名称 |  |

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| 開始年月日 | 1.平成2.令和 |  |  | 年 |  |  | 月 |  |  | 日 | 中止年月日 | 令和 |  |  | 年 |  |  | 月 |  |  | 日 |
| 中止理由 | 1.非該当　3.医療機関入院　4.死亡　5.その他　6.介護老人福祉施設入所　7.介護老人保健施設入所　9.介護医療院入所 |

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| 給付費明細欄 | サービス内容 | サービスコード | 単位数 | 回数 | サービス単位数 | 公費分回数 | 公費対象単位数 | 摘要 |
| 医師居宅療養管理指導Ⅱ3 | 3 | 1 | 1 | 1 | 1 | 6 |  | 2 | 5 | 9 |  | 2 |  |  |  | 5 | 1 | 8 |  |  |  |  |  |  |  |  | 2　15 |
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|  |  | サービスコード表から該当サービスコードを記載する。 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 訪問回数に応じた訪問日を記載する。 |
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| (住所地特例対象者) 給付費明細欄 | サービス内容 | サービスコード | 単位数 | 回数 | サービス単位数 | 公費分回数 | 公費対象単位数 | 施設所在保険者番号 | 摘要 |
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| 請求額集計欄 | ①サービス種類コード／②名称 | 3 | 1 |  |  |  |  |  |  |  |  |  |  |  |
| ③サービス実日数 |  | 2 | 日 |  |  | 日 |  |  | 日 |  |  | 日 |
| ④計画単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑤限度額管理対象単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑥限度額管理対象外単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 給付率（/100） |
| ⑦給付単位数（④⑤のうち少ない数）＋⑥ |  |  |  | 5 | 1 | 8 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 保険 |  | 9 | 0 |
| ⑧公費分単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 公費 |  |  |  |
| ⑨単位数単価 | 1 | 0 | 0 | 0 | 円／単位 |  |  |  |  | 円／単位 |  |  |  |  | 円／単位 |  |  |  |  | 円／単位 | 合計 |
| ⑩保険請求額 |  |  | 4 | 6 | 6 | 2 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 4 | 6 | 6 | 2 |
| ⑪利用者負担額 |  |  |  | 5 | 1 | 8 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 5 | 1 | 8 |
| ⑫公費請求額 |  |  |  |  |  | 0 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑬公費分本人負担 |  |  |  |  |  | 0 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| 社会福祉法人等による軽減欄 | 軽減率 |  |  |  |  | ％ | 受領すべき利用者負担の総額（円） | 軽減額（円） | 軽減後利用者負担額（円） | 備考 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | 枚中 |  | 枚目 |  |

**様式第二**（附則第二条関係）

**記載例**

居宅サービス・地域密着型サービス介護給付費明細書

（訪問介護・訪問入浴介護・訪問看護・訪問リハ・居宅療養管理指導・通所介護・通所リハ・福祉用具貸与・定期巡回・随時対応型訪問介護看護・夜間対応型訪問

公費負担医療受給者の場合は番号を記載する。

介護・地域密着型通所介護・認知症対応型通所介護・小規模多機能型居宅介護（短期利用以外）・小規模多機能型居宅介護（短期利用）・複合型サービス（看護小規模多

機能型居宅介護・短期利用以外）・複合型サービス（看護小規模多機能型居宅介護・短期利用））

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| 公費負担者番号 | 1 | 2 | 2 | 4 | 0 | 0 | 0 | 0 |  |  |  |  |  |  |  |  | 令和 | 0 | 4 | 年 | 0 | 4 | 月分 |
| 公費受給者番号 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 0 | 0 | 0 | 9 | 9 | 9 | 9 |  |  |  |  |  |  |  |  |  | 保険者番号 | 2 | 4 | 0 | 0 | 0 | 0 |

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| 被保険者 | 被保険者番号 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |  | 請求事業者 | 事業所番号 | 2 | 4 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (ﾌﾘｶﾞﾅ)氏名 | カイゴ　イチロウ | 事業所名称 | ○○医院 |
| 介護　一郎 |
| 所在地 | 〒 | 9 | 9 | 9 | － | 9 | 9 | 9 | 9 |  |
| 生年月日 | 1.明治　2.大正　3.昭和 | 性別 | 1．男　2．女 | ○○県○○市○○町9-9 |
| 1 | 6 | 年 | 0 | 3 | 月 | 3 | 1 | 日 |
| 要介護状態区分 | 要介護1・2・3・4・5 |
| 認定有効期間 | 1. 平成2.令和 | 0 | 3 | 年 | 0 | 4 | 月 | 0 | 1 | 日 | から | 連絡先 | 電話番号　059-999-9999 |
| 令和 | 0 | 5 | 年 | 0 | 3 | 月 | 3 | 1 | 日 | まで |

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| 居宅サービス計画 | １．居宅介護支援事業者作成　　　　　　２．被保険者自己作成　　　　 |
| 事業所番号 |  |  |  |  |  |  |  |  |  |  | 事業所名称 |  |

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| 開始年月日 | 1.平成2.令和 |  |  | 年 |  |  | 月 |  |  | 日 | 中止年月日 | 令和 |  |  | 年 |  |  | 月 |  |  | 日 |
| 中止理由 | 1.非該当　3.医療機関入院　4.死亡　5.その他　6.介護老人福祉施設入所　7.介護老人保健施設入所　9.介護医療院入所 |

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| 給付費明細欄 | サービス内容 | サービスコード | 単位数 | 回数 | サービス単位数 | 公費分回数 | 公費対象単位数 | 摘要 |
| 医師居宅療養管理指導Ⅱ3 | 3 | 1 | 1 | 1 | 1 | 6 |  | 2 | 5 | 9 |  | 2 |  |  |  | 5 | 1 | 8 |  |  |  |  |  |  |  |  | 2　15 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | サービスコード表から該当サービスコードを記載する。 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 訪問回数に応じた訪問日を記載する。 |
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| (住所地特例対象者) 給付費明細欄 | サービス内容 | サービスコード | 単位数 | 回数 | サービス単位数 | 公費分回数 | 公費対象単位数 | 施設所在保険者番号 | 摘要 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 請求額集計欄 | ①サービス種類コード／②名称 | 3 | 1 |  |  |  |  |  |  |  |  |  |  |  |
| ③サービス実日数 |  | 2 | 日 |  |  | 日 |  |  | 日 |  |  | 日 |
| ④計画単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑤限度額管理対象単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑥限度額管理対象外単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 保険者負担率+公費負担率を記載する。 |  |  |  |  |  |  |  | 給付率（/100） |
| ⑦給付単位数（④⑤のうち少ない数）＋⑥ |  |  |  | 5 | 1 | 8 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 保険 |  | 9 | 0 |
| ⑧公費分単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 公費 | 1 | 0 | 0 |
| ⑨単位数単価 | 1 | 0 | 0 | 0 | 円／単位 |  |  |  |  | 円／単位 |  |  |  |  | 円／単位 |  |  |  |  | 円／単位 | 合計 |
| ⑩保険請求額 |  |  | 4 | 6 | 6 | 2 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 4 | 6 | 6 | 2 |
| ⑪利用者負担額 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑫公費請求額 |  |  |  | 5 | 1 | 8 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 5 | 1 | 8 |
| ⑬公費分本人負担 |  |  |  |  |  | 0 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| 社会福祉法人等による軽減欄 | 軽減率 |  |  |  |  | ％ | 受領すべき利用者負担の総額（円） | 軽減額（円） | 軽減後利用者負担額（円） | 備考 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | 枚中 |  | 枚目 |  |