**介護給付費過誤申立書**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 事業所番号 |  |  |  |  |  |  |  |  |  |  |
| 事業所名称 |  | | | | | | | | | |
| 事業所所在地 | 〒　　　　　　― | | | | | | | | | |
|  | | | | | | | | | |
| 連絡先 | 電話番号　　　　　　　　　　　　　　　（担当　　　　　　　　） | | | | | | | | | |

**古　殿　町　長　　様**

　　　　　　　　　　　　　　　　　　　　　　　（　　　枚中　　枚）

下記の介護給付について、過誤を申し立てます。

**年　　月　　日**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 事業所番号 | | | | | | | | | | 被保険者番号  被保健者氏名 | | | | | | | | | | サービス  提供年月 | 申立事由  コード | | | | 申立事由 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 年 月 |  |  |  |  |  |
|  | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 年 月 |  |  |  |  |  |
|  | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 年 月 |  |  |  |  |  |
|  | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 年 月 |  |  |  |  |  |
|  | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 年 月 |  |  |  |  |  |
|  | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 年 月 |  |  |  |  |  |
|  | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 年 月 |  |  |  |  |  |
|  | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 年 月 |  |  |  |  |  |
|  | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 年 月 |  |  |  |  |  |
|  | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 年 月 |  |  |  |  |  |
|  | | | | | | | | | |