**介護給付費過誤申立書**

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| 保険者番号 |  |  |  |  |  |  |
| 保険者名 |  | | | | | |
| 所在地 | 〒　　　　　- | | | | | |
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| 連絡先 | 電話番号 | | | | | |

**古　殿　町　長　　様**

下記の介護給付について、過誤を申し立てます。

**平成　　年　　月　　日**

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| 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 |
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