介護給付費過誤申立書（通常・同月）

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| **事業書番号** |  |  |  |  |  |  |  |  |  |  |
| **事業所名** |  |
| **所在地** | 〒 |
|  |
| **連絡先** |  |

五霞町長 殿

下記の介護給付について、過誤を申し立てます。 令和　　　年　 月 日

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| --- | --- | --- | --- | --- | --- | --- |
| **保険者番号** | **被保険者番号** | **サービス****提供年月** | **合計単位数(合計)** | **食事提供費** | **申立事由****コード** | **申立理由** |
| 　　　　**被保険者氏名** |
| 0 | 8 | 5 | 4 | 2 | 3 |  |  |  |  |  |  |  |  |  |  | 　年 　　月 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 0 | 8 | 5 | 4 | 2 | 3 |  |  |  |  |  |  |  |  |  |  | 　年 月 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 0 | 8 | 5 | 4 | 2 | 3 |  |  |  |  |  |  |  |  |  |  | 　年 月 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 0 | 8 | 5 | 4 | 2 | 3 |  |  |  |  |  |  |  |  |  |  | 　年 月 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 0 | 8 | 5 | 4 | 2 | 3 |  |  |  |  |  |  |  |  |  |  | 　年 月 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 0 | 8 | 5 | 4 | 2 | 3 |  |  |  |  |  |  |  |  |  |  | 　年 月 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 0 | 8 | 5 | 4 | 2 | 3 |  |  |  |  |  |  |  |  |  |  | 　年 月 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 0 | 8 | 5 | 4 | 2 | 3 |  |  |  |  |  |  |  |  |  |  | 　年 月 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 0 | 8 | 5 | 4 | 2 | 3 |  |  |  |  |  |  |  |  |  |  | 　年 月 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 0 | 8 | 5 | 4 | 2 | 3 |  |  |  |  |  |  |  |  |  |  | 　年 月 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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