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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