**過 誤 申 立 書**

事業所　→　保険者

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| **事業所番号** |  |
| **事業所名称** |  |
| **担当者名** |  |
| **電話番号** |  |
| **ＦＡＸ番号** |  |

**保険者番号 ０７５４５７**

**保険者名 大熊町**

**下記の介護給付について、過誤を申し立てます。**

**申立年月日　　　 年 　　月 　　日**

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| 番号 | 被保険者番号 | | | | | | | | | | フリガナ | サービス提供年月 | 申立事由  コード | 申　　　立　　　事　　　由 |
| 被保険者氏名 |
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保険者　　電話番号（0240－23－7226）

担当課　保健福祉課　介護保険係