Claim for Payment of Medical Care Costs for Insured Person or Dependent (for massages)

Information on insured person/Application details

Insurance card code and number	Code: ●●	Number: XXXX	Name of affiliated office/department	XXXX Co., Ltd., XXXX Branch Telephone number (ext.) 03-1234-5678（999）
Name of insured person	Furigana ケンポ タロウ Taro Kempo		Date of birth	Showa / Heisei ●● (Y) ●● (M) ●● (D)
Address, telephone number, etc. (daytime phone number)	〒123-4567 XXXX Condominium, #456 1-2-3 XXXX-cho, XXXX Ward, Tokyo Phone number: 090-7891-2345		E-mail address	XXXX@XXXX.ne.jp
Name of person who received medical care	Hanako Kempo		Date of birth of person who received medical care	Showa / Heisei ●● (Y) ●● (M) ●● (D)
Cause of illness or injury	Sequela due to cerebral hemorrhage		Was the need for medical care caused by a third party (traffic accident, etc.)?	No / Yes

Procedure column

Date of first medical care	Procedures period	Actual number of days	Claim classification
H / R (Y) (M) (D)	From Heisei/Reiwa (Y) (M) (D) to Heisei/Reiwa (Y) (M) (D)	days	New / Continuation
Name of injury/illness or symptom			Outcome Continuation / Cured / Discontinued / Transfer to a different practitioner
Massage	Trunk yen x time(s) = yen Right upper yen x time(s) = yen		Summary
Correction of structural def			
Hot fomentation			
Hot fomentation / electro thera			
House call fee Up to			
House call fee More tha			
Fees for issuing treatment report (Previous date: (M			
Total			

Ask the masseuse to fill this space out.

Date of procedure
Visit to the practice: ○
House call: ◎

Month 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Treatment certificate

Procedures were carried out as shown above and related fees were received.

Health center registration classification: 1. Address of clinic 2. Address of professional practitioner making a house-call, etc.

Reiwa (Y) (M) (D)

Registration code number (registration number of reported practitioner) _____

Clinic Address
Name
Phone number

Clinic manager Name

Remarks

Record of consent

Name of consenting physician	Address	Date of consent	Name of injury / illness	Period requiring medical care
		Reiwa (Y) (M) (D)		

*If you wish to delegate receipt, please complete the authorization letter.

Authorization Letter

☑(1) I hereby entrust the receipt of benefits based on this claim to the employer. ← Insert a check (☑) in the box of the applicable item.

☐(2) I hereby entrust the receipt of benefits based on this claim to the representative listed below. Reiwa (Y) (M) (D)

Insured person (applicant)	Name	Taro Kempo
Representative (individual actually receiving benefits)	Name	

Information on transfer

Name of financial institution		number	123
Type of account	Sav		Taro Kempo

Please fill in the section for the authorization letter, except for persons enrolled in voluntary and continuous health insurance coverage and retirees. If you are a person enrolled in voluntary and continuous health insurance coverage or a retiree, please fill in the section for information on transfer destination.

Remarks

Individual number (not required when card)
*If you entered your individual numbe
One of the following: (1) Copy of indi
・When attaching (1) or (2) above, also attach one of the following: copy of driver's license or copy of passport

ate request received (stamp)