laim for Health Insurance Payment of Medical Care Costs for Insured Person or Dependent [Advance Payment on Behalf of Third Part

Information on insured person	Insurance card code and number	Code	Number	Name of affiliated office/department	Phone number (Ext.)
	Name	Furigana		Date of birth	Showa / Heisei (Y) (M) (D)
	Address, telephone number, etc. of applicant (daytime phone number)	〒			Phone number (Ext.)
	Employee ID number			E-mail address	

Application details	Person undergoing medical treatment (circle the applicable person)	Insured person / Family member (dependent)	Name of person undergoing medical treatment	
	Name of injury / illness		Date of birth of person undergoing medical treatment	Showa / Heisei / Reiwa (Y) (M) (D)
	Cause and progress of symptoms			
	Name of medical institution where examination was conducted		Address of medical institution where examination was conducted	
	Period during which medical treatment was conducted	From H/R (Y) (M) (D) to H/R (Y) (M) (D) days	If hospitalized during the period listed on the left, the period of that hospitalization	From H/R (Y) (M) (D) to H/R (Y) (M) (D) days
	Cost of medical care	yen	Content of treatment	
	Reason for claim for payment of medical care costs (Circle the applicable reason)	1. I had just entered the company and had not yet received my insurance card 2. I was not carrying my insurance card, but I was forced to receive care at a medical institution due to sudden illness/injury 3. I used my previous insurance card 4. Other ( )		
	Was the need for medical care caused by a third party (traffic accident, etc.)?	No / Yes	If the need for medical care was caused by a third party, please describe the situation	

*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. to H/R (Y) (M) (D)		
	Insured person (applicant)	Name	
	Representative (individual actually receiving benefits)	Name	

Information on transfer	Name of financial institution	Bank / Shinkin bank (credit treasury)		Central branch / Branch		Branch number	
	Type of account	Savings account / Checking account	Account number		Name of account holder (Katakana)		

[Documents for Attachment]

1. Certificate of medical remuneration (original) *If you are unable to attach the receipt, please obtain a physician's certificate for the second sheet (itemized (medical treatment) receipt).

2. Receipt (original copy)

Remarks	Individual number (not required when entering the code and number from the insured person's card)	
	*If you entered your individual number, please attach the following documents to confirm your individual number and identity. One of the following: (1) Copy of individual number notification card, (2) Copy of certificate of residence listing individual number, (3) Copy of individual number card (both sides) ・When attaching (1) or (2) above, also attach one of the following: copy of driver's license or copy of passport	

Date request received (stamp)

Mercari Health Insurance Association

Itemized (Medical Treatment) Receipt (Physician's Certificate)

*Please submit if you are unable to attach the certificate of medical remuneration.

Name of patient

Month of medical treatment

Name of injury / illness

Actual number of days of medical treatment

Initial examination	Initial examination	time(s)	points	Hospitalization	Date of hospitalization:			
	After-hours	time(s)	points		Bed	Treatment	Basic hospitalization fees/additional fees	
	Days off	time(s)	points				x days	points
	Late-night	time(s)	points				x days	points
Follow-up visit	Follow-up visit	time(s)	points				x days	points
	Additional fees for outpatient care	time(s)	points				x days	points
	After-hours	time(s)	points				x days	points
	Days off	time(s)	points				Specified hospital charges/ Other fees	
	Late-night	time(s)	points					
Medical administration			points	Dietary habits	Standard	yen x	time(s)	
At-home			points		Special	yen x	time(s)	
					Diet	yen x	time(s)	
					Environment	yen x	time(s)	
Administration of drugs	Oral	Single dose	points	Standard (raw)	yen x	time(s)		
	Taken only once	Single dose	points	Special (raw)	yen x	time(s)		
	Topical	Single dose	points	Reduction / Exemption / Deferment / I / II / March				
	Prescription	time(s)	points					
	Narcotic or psychotropic agent	time(s)	points					
	Basic dispensing fee		points					
Injection	Subcutaneous	time(s)	points					
	Intravenous	time(s)	points					
	Other	time(s)	points					
Procedure	Procedure	time(s)	points					
Surgical anesthesia	Operation	time(s)	points					
	Anesthesia	time(s)	points					
Test	Test/pathology	time(s)	points					
Diagnostic imaging		time(s)	points					
Other		time(s)	points	Total	yen			

I hereby certify receipt of the above (medical treatment). Reiwa (Y) (M) (D)

Address of medical institution

Name of medical institution

Name of physician

Telephone number of medical institution ( )