Claim for Payment of Medical Care Costs for Insured Person or Dependent
(for therapeutic devices, therapeutic eye glasses, etc.)

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		Date of injury or onset of illness	H / R (Y) (M) (D)
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 therapeutic devices, etc.	yen	Date of attaching therapeutic devices, etc.	H / R (Y) (M) (D)
Content of treatment	1. Wearing of therapeutic devices, etc. 2. Creation of therapeutic eye glasses, etc. 3. 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. Reiwa (Y) (M) (D)

Name of insured person (Applicant)	Name	
Representative (individual actually receiving benefits)	Name	

Information on transfer destination

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

[For Therapeutic Devices]

1. Physician's certificate, instructions, or written diagnosis (original copy)
2. Receipt (original copy)
3. Written document confirming wearing of the device (photograph of the created device)

[For Therapeutic Eye Glasses, etc.]

1. Physician's written instructions for creation of therapeutic eye glasses, etc.
2. Patient examination/test results
3. 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