Request for Payment of Medical Expenses for Insured Person or Dependent
[for massages]

Information on insured person/Application details

Insurance card code and number	Code	Number	Name of affiliated office/department	Phone number (Ext.)
Name of insured person	Furigana		Date of birth of insured person	(Y) (M) (D)
Address, telephone number, etc. (daytime phone number)	〒 Telephone number ( )		E-mail address	
Name of person who received medical care			Date of birth of person who received medical care	(Y) (M) (D)
Cause of illness or injury			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
(Y) (M) (D)	From (Y) (M) (D)	to (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	Summary
	Right upper limb	yen x time(s) =	yen	
	Left upper limb	yen x time(s) =	yen	
	Right lower limb	yen x time(s) =	yen	
	Left lower limb	yen x time(s) =	yen	
Correction of structural deformities		yen x time(s) =	yen	
Hot fomentation		yen x time(s) =	yen	
Hot fomentation / electro therapy device		yen x time(s) =	yen	
House call fee Up to 4 km		yen x time(s) =	yen	
House call fee More than 4 km		yen x time(s) =	yen	
Fees for issuing treatment report (Previously paid for date: (Month/Year))		yen x time(s) =	yen	
Total			yen	

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.

(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
		Date:		

*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. Date: (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	Other ( )	Account number		Name of account holder (Katakana)	

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)

Works Human Intelligence Health Insurance Society

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