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: 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	●● (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	●● (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
(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 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				
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			

Ask the masseuse to fill this space out.

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 Clinic manager Name	Phone number

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	Taro Kempo
Re... (individual ac...		

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.

Information on transfer			
Name of finar... institution	...h	Branch number	
Type of acc...	...t		

Remarks	
	Individual number (not...
	*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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