Request for Payment of Medical Expenses for Insured Person ~~or Dependent~~
[for acupuncture and moxibustion]

Information on insured person

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 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	Joints are swollen and painful		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: 1. Neuralgia 2. Rheumatism 3. Cervicobrachial syndrome 4. Shoulder periarthritis (frozen shoulder) 5. Lower back pain 6. Cervical sprain (whiplash) 7. Other ( )

Outcome: Continuation / Cured / Discontinued / Transfer to a different practitioner

First time: 1. Acupuncture 2. Acupuncture (combined use of electroacupuncture) 3. Moxibustion 4. Moxibustion (combined use of electric heat therapy device) 5. Combination of acupuncture and moxibustion 6. Combination of acupuncture and moxibustion (combined use of electroacupuncture and electric heat therapy device)

Summary

Second and subsequent procedures						
	Acupuncture	yen	x	time(s) =	yen	
	Acupuncture (combined use of electroacupuncture)	yen	x	time(s) =	yen	
	Moxibustion	yen	x	time(s) =	yen	
	Moxibustion (c					
	Combination o					
	Combination of electroacupunctu					
House						
House						
Fees for issuing treatm						
To						

Ask the acupuncture / moxibustion practitioner to fill this space out.

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

26 27 28 29 30 31

Procedures were carried c … classification … actitioner making a house-call, etc.

Treatment certificate

(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
		(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. Date: ● (Y) ●● (M) ●● (D)

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

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 destination

Name of financi… institution … nch number

Type of accou…

Remarks

Individual number (not re…
*If you entered your indivi…
One of the following: (1) …
・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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