Request for Payment of Medical Expenses for Insured Person or Dependent
[Advance Payment on Behalf of Third Party]

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	Furigana ケンポ タロウ Taro Kempo		Date of birth	●● (Y) ●● (M) ●● (D)
Address, telephone number, etc. of applicant (daytime phone number)	〒123-4567 XXXX Condominium, #456 1-2-3 XXXX-cho, XXXX Ward, Tokyo Telephone number 03-7891-2345			
Employee ID number	1234567		E-mail address	XXXX@XXXX.ne.jp

Application details

Person undergoing medical treatment (circle the applicable person)	Insured person / Family member (dependent)	Name of person undergoing medical treatment	Taro Kempo
Name of injury / illness	Influenza	Date of birth of person undergoing medical treatment	●● (Y) ●● (M) ●● (D)
Cause and progress of symptoms	I had a high fever and underwent an emergency examination at a hospital while traveli		
Name of medical institution where examination was conducted	XXXX Hospital	Address of medical institution where examination was conducted	X-X-X-cho, XXXX City, Fukuoka Prefecture
Period during which medical treatment was conducted	From ● (Y) ● (M) ● (D) to ● (Y) ● (M) ● (D) ● days	If hospitalized during the period listed on the left, the period of that hospitalization	From (Y) (M) (D) to (Y) (M) (D) days
Cost of medical care	12,000 yen	Content of treatment	Underwent medical treatment and received administration of drugs
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. Date: ● (Y) ●● (M) ●● (D)

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

Information on transfer

Name of financial institution	
Type of account	

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.

[Documents for Attach

1. Certificate of medical r d (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)

Works Human Intelligence Health Insurance Society

(20210401)

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

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

If you are unable to have the medical institution issue a Certificate of medical remuneration, please ask the medical institution for a Itemized (Medical Treatment) Receipt.

Name (

Name (

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	yen	x	time(s)	
	Taken only once	Single dose	points		Special	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). (Y) (M) (D)

Address of medical institution

Name of medical institution

Name of physician

Telephone number of medical institution ( )

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