*All the years should be written in the Japanese Calendar system.

記入見本

療　養　費　支　給　申　請　書

Furigana (in Katakana)

Employee Number

Name of Insured Person

Date of Birth: [Showa] / [Heisei] [Year][Month][Date]

Health Insurance Card [Symbol] [Number]

Date of Enrollment: [Showa] / [Reiwa] / [Heisei] [Year][Month][Date]

Date of Loss of Entitlement: [Heisei] / [Reiwa] [Year][Month][Date]

Date of Birth of the Dependant: [Showa] / [Heisei] / [Reiwa] [Year][Month][Date]

Name of Dependant (When a Dependant received treatment)

Relationship to the Insured Person

Name of Injury or Illness (e.g. common cold)

Date of Onset or Injury Reiwa [Year][Month][Date]

Cause and Course of Illness or Injury (e.g. He got a fever in a hotel on a family holiday and was treated in hospital.)

Was it caused by any third-party action? [Yes] / [No]

Name of medical institution where the patient received treatment

[Address] and [Phone Number] of above institution

Treatment Period: From Reiwa [Year][Month][Date] To Reiwa [Year][Month][Date]

For [ ] day(s)

Date of Orthosis Installation: Reiwa [Year][Month][Date]

Total Medical Expense: [ ]JPY
*Please fill in the amount of attached receipt.

[Hospitalisation] / [Outpatient]

Paid 100% expense due to urgent need

Medical visit using previous Insurance Card

Reason for application and attached documents

Please tick the relevant boxes on the right and submit the application with the attached documents.
(*All supporting documents must be originals.)

◎Receipt (original)
◎"A breakdown of medical expenses (receipt)" issued by the medical institution
*The 'medical statement' issued together with the receipt cannot be attached. (For unable to check the details from the statement due to absence of entry showing any name of injury or disease.)

Received medical treatment not covered by Health Insurance (e.g. making of therapeutic orthotics, therapeutic spectacles, etc.)

◎Statement of direction prepared by medical doctor　◎Receipt and statement (original)
◎Photographs of shoe-type orthotics
For more information on photographs of shoe-type orthotics, please refer to the website.
http://www.shiseidokenpo.or.jp/member/application/refund_b.html

Received medical treatment not covered by Health Insurance (e.g. acupuncture, moxibustion, massage)

◎ Medical statement and medical doctor's consent for treatment and receipt (original)

For employee

Power of Attorney

"I authorise the following employer to receive the above benefits."

Reiwa [Year][Month][Date]

Address of Insured Person

Name of Insured Person

For retired persons

No need to fill in these blanks.
(Please fill in here only if claiming after retirement.)

For employer

Certification from employer is required of current employee.

受　付　印

備考欄

【資生堂健康保険組合】202104

Internal