Example（Prosthetic Equipment）

K-001 | P (P)

日立健康保険組合 御中

健康保険 ☐被保険者 ☑被扶養者 療養費請求書（立替払い・治療用装具等）

insured / dependent

Health Insurance Claim for Medical Care Expenses (Advance Payment, Prosthetic Equipment, etc.)

※太枠線内をご記入ください。（記入要領等は、別紙「記入例」をご参照ください）

② 提出日 Submission date	令和 〇〇 年 〇〇 月 〇〇 日	備考	
被保険者証 記号・番号 Health insurance card code and number	記号 番号 1 0 0 0 1 0 0 0 0 0 0 0	被保険者 氏名 Name of insured person	(ﾌﾘｶﾞﾅ) ケンポ マサミ 健保 正美
事業所（会社）名称 Office (company) name	株式会社〇〇〇〇〇	従業員番号 Employee no. / 所属・電話 Affiliation and telephone number	〇〇課 (TEL： 000-000-0000)
対象者氏名 Name of subject person	健保 薫	生年月日 Date of Birth	昭和 平成 令和 6 0 年 0 1 月 1 0 日 (Year Month Date)
		被保険者との続柄 Relationship	配偶者
③ 傷病名 Name of injury/illness	アキレス腱断裂	発病または負傷した日 Date of onset of injury/illness	平成 令和 〇〇 年 8 月 1 日（頃） (Year Month Date)
③ 傷病または負傷の原因 Cause of injury/illness	自宅の階段を踏み外し、右足首を負傷した	④ 診療または装具等の内容（いずれかに✓） Details of examination/treatment, prosthetic equipment, etc.	☐ Medical Treatment/Pharmacy ☑ Fitting of prosthetic equipment, etc.
⑤ 受診した医療機関薬局等 Medical care institution, pharmacy, etc. consulted	住所 Address ☐☐県☐☐市☐☐町１－１－１ / 名称 Name ☐☐☐☐病院	(医師または薬剤師氏名) Doctor or pharmacist name	☐☐ ☐☐
⑥ 診療を受けた期間 Period of examination/treatment	令和〇〇年 8 月 1 日 から (Year Month Date) 現在治療中 日間 / 令和 年 月 日 まで	⑦ 入院期間 Period of hospitalization	令和〇〇年 8 月 1 日 から (Year Month Date) / 令和〇〇年 8 月 9 日 まで
⑧ 診療または装具等に要した費用 Cost required for examination/treatment, prosthetic equipment, etc.	20,000 円 yen	⑨ 治療用装具等領収日 Date of receipt for prosthetic equipment, etc.	令和 〇〇年 8 月 1 0 日 (Year Month Date)
⑩ 傷病の経過（いずれかに✓） Course of illness or injury / illness	☐Recovering well ☑Recovered ☐Under treatment ☐Other( )		
⑪ 療養の給付を受けることができなかった理由（いずれかに✓） Reason the health insurance card could not be used	☐Replacement of health insurance card in process ☐Received treatment at a medical care institution without health insurance card unavoidably due to sudden illness. ☑Because the person cannot receive the insurance benefit for the prosthetic equipment required for treatment, since the equipment was prepared by a party other than a medical care institution. ☐Other ( )		
⑫ 第三者の行為によって負傷したものであるか、ないかの別 Was it due to the actions of a third party (e.g. traffic accident act of violence)?	有 ・ 無 Yes / No No		

About benefit remittance

[Employees]

For those who belong to a company that chooses to receive via the company: Benefits will be remitted to the company based on the power of attorney

→ Sign the power of attorney field

For those who belong to a company that chooses individual remittance: Benefits will be remitted to the account notified to Hitachi Health Insurance Society

[Voluntarily and continuously insured persons and special-case retired insured persons]

Benefits will be remitted to the account notified to Hitachi Health Insurance Society.

⑬ 委任状 Power of attorney

本請求に基づく給付金に関する受領を事業所に委任します

I hereby authorize the above company to receive the benefit based on this application. 健保 正美

令和 〇〇 年 8 月 2 0 日 (Year Month Date) 被保険者氏名： Name of insured person

Notes

(1) Payment date and payment method

- If the form is received by the health insurance association by the 20th of the month, payment will be made on the 15th of the following month. (The payment date is moved forward if the 15th falls on a weekend or holiday.) However, depending on the contents of the application, the health insurance association might need more time to review it, delaying payment by one or more months. (Some offices might set their own deadlines.)
- The available payment options are (1) Direct payment from the health insurance association and (2) Payment via office with salary payment. You can find out more by contacting the person in charge of health insurance in your] office (company).

(2) Notice of final amount

- You can verify the payment amount in the Notice of Medical Costs/Notice of Cash Benefit Decision. This notice is available from MY HEALTH WEB on the Hitachi Health website.

Use this application form in the following circumstances:

When a person is fitted with a prosthetic device or other medical equipment by doctor's order and the full amount of the cost is paid in advance. (The doctor's written opinion must be provided.)

◆ How to fill in the form (match the number to the example entry)

① Tick (✓) whether the application is for the insured person or a dependent.

② Enter the submission date.

③ If the prosthetic device is required due to an injury, describe in detail the circumstances under which the injury occurred.

④ Tick (✓) [治療用装具等の装着]Wearing of prosthetic device.

⑤ Enter the address and name of the medical institution and the name of physician.

⑥ Enter the period during which the person received medical care. As the number of days, enter the number of days medical care was received.

⑦ If the medical care required hospitalization, enter the time period during which the person was hospitalized.

⑧ Enter the amount on the receipt.

⑨ Enter the date on the receipt.

⑩ Tick (✓) the item that applies (if none apply, tick [その他]Other and write the specifics in the space provided)

⑪ Tick (✓) [治療上必要な装具等の作成業者が医療機関でなく保険給付が受けられないため]Because the maker of the prosthetic device or other item required for treatment is not a medical institution and does not accept insurance.

⑫ Circle [有]Yes if the injury is due to the act of a third party, such as a traffic accident. In this case, let the health insurance association know as soon as possible.

⑬ If your office (company) passes on benefits when paying salary, enter your information here. Check with the health insurance representative at your office (company) in regard to whether a letter of power of attorney is needed.

Note: When correcting the information you entered, draw a double line through the information to be corrected and enter the correct information and the name of the insured person.

◆Required Attachments

① A receipt (original) explaining the nature of the device in detail.

② A written opinion by a doctor explaining why the prosthetic device is needed to treat the injury or illness (using form K-007 designated by the insurance provider) (Original). Alternatively, attach a doctor's certificate (original) issued by the medical institution clarifying the need for the device.

③ If the device is orthotic footwear, submit a photograph of the footwear itself (it must be a photograph of the device the patient actually wears).

◆Address for Submission

To minimize the chance of documents being lost, we recommend that you use registered mail or similar means.

① For the general insured (employee): Submit to the person in charge of health insurance in your office (company).

② For voluntarily and continuously insured persons and special-case retired insured persons: Submit to the health insurance association. (The address for submission is listed under "Address of Insurer" on the insurance card.)

◆Submission Deadline

The request must be submitted (and received by the health insurance association) within two years of the bill being paid.