Example（Eyeglasses for the treatment of amblyopia in children）

K-001 | P (P)

日立健康保険組合 御中

① insured / dependent

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）

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 ○○ 年 ○○ 月 ○○ 日

備考:

被保険者証 記号・番号 Health insurance card code and number: 記号 1000 / 番号 1000000

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○○○○○

従業員番号 Employee no.:

所属・電話 Affiliation and telephone number: ○○課 (TEL： 000-000-0000)

対象者氏名 Name of subject person: 健保 真

生年月日 Date of Birth: 昭和 平成 令和 2 9 年 0 2 月 2 8 日

被保険者との続柄 Relationship: 子

傷病名 Name of injury/illness: 左不同視弱視

③ 発病または負傷した日 Date of onset of injury/illness: 平成・令和 年 不 明 (頃)

④ 傷病または負傷の原因 Cause of injury/illness: 先天性

⑤ 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.

⑥ 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): □□ □□

⑦ 診療を受けた期間 Period of examination/treatment: 令和○○年 8月 1日 から 現在治療中 日間 / 令和 年 月 日 まで

入院期間 Period of hospitalization: 令和 年 月 日 から / 令和 年 月 日 まで

⑧ 診療または装具等に要した費用 Cost (advised for examination/treatment, prosthetic equipment, etc.): 30,000 円 yen

⑨ 治療用装具等領収日 Date of receipt for prosthetic equipment, etc.: 令和 ○○年 8月 10日

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 ( )

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

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.

⑫ 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 ○○年 8月 20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 dependent aged 8 or younger is fitted with therapeutic eyewear to treat amblyopia, strabismus, or refractive error after congenital cataract surgery by doctor's orders, for which the insured person paid the full amount out of pocket:

Note 1: Whether the dependent was under 9 years of age at the time is determined by the date of the receipt provided when the eyewear was purchased.

Note 2: A person is considered to require treatment if they have a doctor's certificate stating that the treatment by therapeutic eyewear is expected to be therapeutically effective.

Frequency of Payment: (1) 4 years of age and younger: Payment is approved only if it has been at least a year since the therapeutic eyeglasses were updated
(2) 5 years of age or older: Payment is approved only if it has been at least two years since the therapeutic eyeglasses were updated

Note: Age and duration of wear are determined by the date of the receipt provided when the eyewear was purchased.

Note: Based on the provisions of the Child Welfare Law, the allowance for therapeutic eyewear is as follows:
Eyewear for amblyopia: ¥38,902, Contact lens (x1): ¥16,324
These are the maximum amounts, minus any co-payment.

◆ 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 [発病または負傷した日]Date of onset of illness or injury is unknown, then state as such in this field.
④ If the [傷病または負傷の原因]Cause of onset of illness or injury is unknown, then state as such in this field.
⑤ Tick (✓) [治療用装具等の装着]Wearing of prosthetic device.
⑥ Enter the address and name of the medical institution and the name of physician.
⑦ Enter the period during which the person received medical care. As the number of days, enter the number of days medical care was received.
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 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 The receipt issued when the therapeutic eyewear was created or purchased (Original)
(Either addressed to the subject or with a note naming the subject)
② Instructions for creating the therapeutic eyewear prepared by the physician in charge of the patient's care (Copy)
Alternatively, a doctor's certificate clearly stating the medical necessity of the eyewear (Original)
③ The results of the patient's medical tests (Copy, not needed if (2) contains the results of visual acuity and other tests)

◆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.