

Example (When an insurance card such as National Health Insurance card was used and medical expenses were reimbursed)

K-001 P (P))
 日立健康保険組合 御 (1)
健康保険 被保険者 被扶養者 **療養費請求書** (立替払い・治療用器具等)
 Health Insurance Claim for Medical Care Expenses (Advance Payment, Prosthetic Equipment, etc.)
 ※本枠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 10000 10000000	被保険者 氏名 Name of insured person	ケンボ 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.	〇〇課
対象者氏名 Name of subject person	健保 薫	生年月日 Date of Birth	昭和 年 月 日 平成 6 年 0 月 1 日 令和 年 月 日 被保険者 との続柄 Relationship 配偶者
傷病名 Name of injury/illness	急性胃炎	発病または 負傷した日 Date of onset of injury/illness	平成 令和 年 月 日 (頃) 8 月 1 日
傷病または 負傷の原因 Cause of injury/illness	不明	3	<input checked="" type="checkbox"/> Medical Treatment/Pharmacy <input type="checkbox"/> Fitting of prosthetic equipment, etc.
4 受診した 医療機関 薬局等 Medical care institution/pharmacy, etc. consulted	住所 Address 〇〇県〇〇市〇〇町1-1-1	名称 Name 〇〇〇病院	(医師または薬剤師氏名) Doctor or pharmacist name 〇〇 〇〇
5 診療を 受けた期間 Period of examination/treatment	令和〇〇年 8 月 1 日 から 令和〇〇年 8 月 1 日まで 1 日間	6 入院期 Period of hospitalization	令和 年 月 日 から 令和 年 月 日 まで
7 診療または 器具等に 要した費用 Cost required for examination/treatment, prosthetic equipment, etc.	20,000 円 yen	治療用器具等 領収日 Date of receipt for prosthetic equipment, etc.	令和 年 月 日
8 傷病の経過 Cause of illness or injury/illness	<input type="checkbox"/> Recovering well <input type="checkbox"/> Recovered <input type="checkbox"/> Under treatment <input type="checkbox"/> Other()		
9 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	<input checked="" type="checkbox"/> Replacement of health insurance card in process <input type="checkbox"/> Received treatment at a medical care institution without health insurance card unavoidably due to sudden illness. <input type="checkbox"/> 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.		
10 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 <input type="checkbox"/> 無 <input checked="" type="checkbox"/>		
11 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 〇 日 被保険者氏名		

Notes

- 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).
- 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 an insurance card from a previous provider was used, such as a card for National Health Insurance or another provider, and the medical expenses were reimbursed

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

- Tick (✓) whether the application is for the insured person or a dependent.
- Enter the submission date.
- Tick (✓) [診療・投薬]Medical Treatment/Pharmacy.
- Enter the address and name of the medical institution and the name of physician or pharmacist. (If you do not know the name of the physician or pharmacist, you can leave those fields blank.)
- Enter the period during which the person received medical care. As the number of days, enter the number of days medical care was received. (If the period and number of days are unknown, you can leave them blank.)
- If the medical care required hospitalization, enter the time period during which the person was hospitalized.
- Enter the amount on the receipt.
- Tick (✓) the item that applies (if none apply, tick [その他]Other and write the specifics in the space provided)
- Tick (✓) [その他]Other and enter the reason.
- 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.
- 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

- The receipt issued by National Health Insurance or other health insurance association (Original) Alternatively, a payment slip with receipt stamp (Original)
- Certificates of medical remuneration (issued by the insurer that reimbursed the medical fees) Attach the envelope containing the certificates of medical remuneration **without opening it.**

◆ Address for Submission

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

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