Example

K-011 | P (P)

日立健康保険組合 御中

健康保険 ①☐被保険者 ☑被扶養者 (insured / dependent) 海外療養費請求書(令和〇〇年〇月診療分)

Health Insurance Claim for Overseas Medical Care Expenses

※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）

③ 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 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)
渡航目的 (いずれかに✔) Purpose of travel	☑業務上 Occupational ☐その他（旅行等） Other (travel, etc.)	渡航期間 Period of travel	平成・令和 年 月 日から Year Month Date 平成・令和 年 月 日まで
		渡航先国名 Country of travel	アメリカ
被保険 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 年 0 月 1 日 1
		被保険者との続柄 Relationship	配偶者
傷病名 Name of injury/illness	急性大腸炎	発病または負傷した日 Date of onset of injury/illness	平成・(令和) 〇〇年 〇月 〇日（頃） Year Month Date
④ 傷病または負傷の原因及びその経過 Cause of injury/illness	夕食に出た魚で食あたり	Was it due to the actions of a third party (e.g., traffic accident, act of violence)?	
⑤ 受診した医療機関 Medical care institution, pharmacy, etc. consulted	名称 Name: □□□□病院 住所 Address: □□□□□□□□	⑥ 第三者行為対象の有無 (いずれかに✔)	☐有 Yes ☑無 No
⑦ 区分 (いずれかに✔) Category	☐入院 Inpatient ☑入院外 Outpatient	診療開始日 Start date of examination/treatment	平成 令和 年 月 日
		診療を受けた期間・日数 Period of examination/treatment	令和〇〇年〇月〇日から Year Month Date 令和〇〇年〇月〇日まで 1 日間 ⑧
⑨ 診療に要した費用 Cost required for examination/treatment	別紙証憑書類の通り (現地価 1,800ドル)	療養の給付を受けることができなかった理由 Reason the health insurance card could not be used	☑Received examination/treatment at overseas job posting ☐Received examination/treatment while traveling overseas ☐Other( ) ⑩

About benefit remittance
[Employees]
Benefits will be remitted to the company based on the power of attorney → Sign the power of attorney field
[Voluntarily and continuously insured persons and special-case retired insured persons]
Benefits will be remitted to the account notified to Hitachi Health Insurance Society.

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.
令和 〇〇 年 〇 月 〇 日 (Year Month Date)
被保険者氏名： 健保 正美 ⑪ (Name of insured person)

Notes

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 you received medical treatment at an overseas medical institution while posted abroad and paid the full bill in the local currency with expectation of reimbursement

PLEASE NOTE:
The health insurance association will not make a direct overseas payment, and will instead pay you through your employer (office). Submit this form to your employer (office). (Note that this does not apply to voluntarily and continuously insured persons and special-case retired insured persons.)

◆ 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 Prepare a new form for each month treatment was received, each treatment subject, and each instance of outpatient and inpatient treatment.
③ Enter the submission date.
④ If the prosthetic device is required due to an injury, describe in detail the circumstances under which the injury occurred.
⑤ Enter the address and name of the medical institution.
⑥ 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.
⑦ Tick (✓) the item that applies.
⑧ Enter the period during which the person received medical care. As the number of days, enter the number of days medical care was received.
⑨ Enter the amount 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 Because benefits will be paid via the employer, you must fill in this section.
For voluntarily and continuously insured persons and special-case retired insured persons, you can leave this space blank because payment will be made to the bank account on record with the health insurance association.

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 by the medical institution or other treatment provider (Original)
② Medical Consultation Details (Statement) (For dental) (Medical Insurance Form K-012) (Original)
Or Medical Consultation Details (Statement) (Medical Insurance Form K-013) (Original)
③ Overseas Medical Care Expenses (Japanese translation) (Medical Insurance Form K-014)
④ A passport copy that clearly shows the period of travel (including the name page and the pages on which the arrival and departure stamps can be verified)
Alternatively, a copy of documentation such as an airline ticket that proves the fact that the subject traveled abroad

Note: This evidence is not needed when travelling for business (this applies to overseas assignees, accompanying family members, and overseas business travelers).

◆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.