Request for Payment of Medical Expenses for Insured Person or Dependent
[Advance Payment on Behalf of Third Party]

Information on insured person				
Insurance card code and number	Code: / Number:		Name of affiliated office/department	Phone number (Ext.)
Name	Furigana		Date of birth	(Y) (M) (D)
Address, telephone number, etc. of applicant (daytime phone number)	〒 Phone number (Ext.)			
Employee ID number			E-mail address	

Application details			
Person undergoing medical treatment (circle the applicable person)	Insured person / Family member (dependent)	Name of person undergoing medical treatment	
Name of injury / illness		Date of birth of person undergoing medical treatment	(Y) (M) (D)
Cause and progress of symptoms			
Name of medical institution where examination was conducted		Address of medical institution where examination was conducted	
Period during which medical treatment was conducted	From (Y) (M) (D) to (Y) (M) (D) days	If hospitalized during the period listed on the left, the period of that hospitalization	From (Y) (M) (D) to (Y) (M) (D) days
Cost of medical care	yen	Content of treatment	
Reason for claim for payment of medical care costs (Circle the applicable reason)	1. I had just entered the company and had not yet received my insurance card 2. I was not carrying my insurance card, but I was forced to receive care at a medical institution due to sudden illness/injury 3. I used my previous insurance card 4. Other ( )		
Was the need for medical care caused by a third party (traffic accident, etc.)?	No / Yes ※f the answer is "yes," a separate notification is required.	Was the need for medical care caused by to work or on the way to work?	No / Yes ※If the answer is "yes," a separate notification is required.

*If you wish to delegate receipt, please complete the authorization letter.

Authorization Letter		
I hereby entrust the receipt of benefits based on this claim to the representative listed below. Date:		
Insured person (applicant)	Name	
Representative (individual actually receiving benefits)	Name	

Information on transfer destination					
Bank Number		Branch number			
Name of financial institution	Bank Shinkin bank (credit treasury)	Central branch branch			
Type of account	Savings account Checking account Other ( )	Account number		Name of account holder (Katakana)	

[Documents for Attachment]

1. Certificate of medical remuneration (original) *If you are unable to attach the receipt, please obtain a physician's certificate for the second sheet (itemized (medical treatment) receipt).

2. Receipt (original copy)

Remarks		
Individual number (not required when entering the code and number from the insured person's card)		
*If you entered your individual number, please attach the following documents to confirm your individual number and identity. One of the following: (1) Copy of individual number notification card, (2) Copy of certificate of residence listing individual number, (3) Copy of individual number card (both sides) ・When attaching (1) or (2) above, also attach one of the following: copy of driver's license or copy of passport		

Date request received (stamp)

Accenture Health Insurance Society

(20220401)

Itemized (Medical Treatment) Receipt (Physician's Certificate)

*Please submit if you are unable to attach the certificate of medical remuneration.

Name of patient

Name of injury / illness

Month of medical treatment

Actual number of days of medical treatment

Category	Item			Category	Item				
Initial examination	Initial examination	time(s)	points	Hospitalization	Date of hospitalization:				
	After-hours	time(s)	points		Bed	Treatment	Basic hospitalization fees/additional fees		
	Days off	time(s)	points				x	days	points
	Late-night	time(s)	points				x	days	points
Follow-up visit	Follow-up visit	time(s)	points				x	days	points
	Additional fees for outpatient care	time(s)	points				x	days	points
	After-hours	time(s)	points				x	days	points
	Days off	time(s)	points				Specified hospital charges/ Other fees		
	Late-night	time(s)	points						
Medical administration			points	Dietary habits	Standard	yen	x	time(s)	
					Special	yen	x	time(s)	
At-home			points		Diet	yen	x	time(s)	
					Environment	yen	x	time(s)	
Administration of drugs	Oral	Single dose	points	Standard		yen	x	time(s)	
	Taken only once	Single dose	points	Special		yen	x	time(s)	
	Topical	Single dose	points	Reduction / Exemption / Deferment / I / II / March					
	Prescription	time(s)	points						
	Narcotic or psychotropic agent	time(s)	points						
	Basic dispensing fee		points						
Injection	Subcutaneous	time(s)	points						
	Intravenous	time(s)	points						
	Other	time(s)	points						
Procedure	Procedure	time(s)	points						
Surgical anesthesia	Operation	time(s)	points						
	Anesthesia	time(s)	points						
Test	Test/pathology	time(s)	points						
Diagnostic imaging		time(s)	points						
Other		time(s)	points	Total					yen

I hereby certify receipt of the above (medical treatment). (Y) (M) (D)

Address of medical institution

Name of medical institution

Name of physician

Telephone number of medical institution ( )

(20220401)