Request for Payment of Medical Expenses for Insured Person or Dependent

[for therapeutic devices, therapeutic eye glasses, etc.]

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	
	Name of injury / illness			Date of birth of person undergoing	(Y) (M) (D)
	Cause and progress of symptoms			Date of injury or onset of illness	(Y) (M) (D)
	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 therapeutic devices, etc.	yen		Date of attaching therapeutic devices, etc.	(Y) (M) (D)
	Content of treatment	1. Wearing of therapeutic devices, etc. 2. Creation of therapeutic eye glasses, etc. 3. Other ( )			
	Was the need for medical care caused by a third party (traffic accident, etc.)?	No / Yes		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 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

[For Therapeutic Devices]

1. Physician's certificate, instructions, or written diagnosis (original copy)
2. Receipt (original copy)
3. Written document confirming wearing of the device (photograph of the created Shoe-shaped orthotic device)

[For Therapeutic Eye Glasses, etc.]

1. Physician's written instructions for creation of therapeutic eye glasses, etc.
2. Patient examination/test results
3. 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)