Request for Payment of Medical Expenses for Insured Person or Dependent
[for massages]

Information on insured person/Application details

Insurance card code and number	Code: ●● / Number: XXXX	Name of affiliated office/department	XXXX Co., Ltd., XXXX Branch Telephone number (ext.) 03-1234-5678(999)
Name of insured person	Furigana ケンポ タロウ Taro Kempo	Date of birth	●● (Y) ●● (M) ●● (D)
Address, telephone number, etc. (daytime phone number)	〒123-4567 XXXX Condominium, #456 1-2-3 XXXX-cho, XXXX Ward, Tokyo Phone number: 090-7891-2345 E-mail address XXXX@XXXX.ne.jp		
Name of person who received medical care	Hanako Kempo	Date of birth of person who received medical care	●● (Y) ●● (M) ●● (D)
Cause of illness or injury	Sequela due to cerebral hemorrhage	Was the need for medical care caused by a third party (traffic accident, etc.)?	(No) / Yes
Cause of illness or injury	I had been receiving ongoing treatment for my back pain from my doctor, but with no relief from the pain.		
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 ※f the answer is "yes," a separate notification is required.

Procedure column

Date of first medical care (Y) (M) (D)	Procedures period: From (Y) (M) (D) to (Y) (M) (D)	Actual number of days	Claim classification
		days	New / Continuation
Name of injury/illness or symptom			Outcome Continuation / Cured / Discontinued / Transfer to a different practitioner

Massage	Trunk	yen	x	time(s) =	yen	Summary
	Right upper limb	yen	x	time(s) =	yen	
	Left upper limb	yen	x	time(s) =	yen	
Correction of structural def						
Hot fomentation						
Hot fomentation / electro therap						
House call fee	Up to 4					
House call fee	More tha					
Fees for issuing treatment report	(Previous date: (M					
Total						

Ask the masseuse to fill this space out.

Date of procedure
Visit to the practice: ○
House call: ◎

Mo … 6 27 28 29 30 31

Treatment certificate

Procedures were carried out as shown above and related fees were received.

Health center registration classification: 1. Address of clinic 2. Address of professional practitioner making a house-call, etc.

(Y) (M) (D)
Registration code number (registration number of reported practitioner)

Clinic Address
Name
Phone number
Clinic manager Name

Remarks

Record of consent

Name of consenting physician	Address	Date of consent	Name of injury / illness	Period requiring medical care
		Date:		

*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	1234		Branch number	567	
Name of financial institution	●●	Bank Shinkin bank (credit treasury)	●●	Central branch branch	
Type of account	(Savings account) Checking account	Other ( )	Account number	1234567	Name of account holder (Katakana): Taro Kempo

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)