Health Insurance Insured Person / Dependent Medical Care Cost Claim (for reimbursement)

***Please fill in the form in Japanese.**

Information on insured person	Insurance Code and Number	Code	Number	Company	
	Full Name	Furigana		Date of birth	Showa / Heisei (Year) / (Month) / (Day) / /
	Address, telephone number, etc. (daytime phone number)	Postal code			Phone number ( )
	Employee ID			Email	

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	Showa/Heisei/Reiwa (Year) / (Month) / (Day) / /
	Cause and reason of symptoms			
	Name of hospital where examination was conducted		Address of hospital where examination was conducted	
	Period during which medical treatment was conducted	From Reiwa (Y) / (M) / (D) to Reiwa (Y) / (M) / (D) days	If hospitalized during the period listed on the left, the period of hospitalization	From Reiwa (Y) / (M) / (D) to Reiwa (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 visited a medical facility shortly after enrollment and was unable to verify my eligibility. 2. I have received a confirmation of eligibility letter, but forgot to bring it with me. 3. To apply for medical expenses returned after losing eligibility for other health insurance 4. Other ( )		
	Was the need for medical care caused by a third party (traffic accident, etc.)?	No / Yes *If yes, another form has to be submitted	Was the need for medical care during your commute to work?	No / Yes *If yes, another form has to be submitted

※Only fill out the following if you wish to transfer funds to another account other than your payroll account

Bank Transfer	Bank Code			Branch Code		
	Bank Name	Bank / Credit Union			Main Branch / Branch	
	Account Type	Savings / Checking / 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 insured code and number)	
	*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)

Salesforce Health Insurance Association

領収(診療)明細書(医師の証明)

※診療報酬明細書(レセプト)の添付が不可能な場合に提出してください。

患者名　　診療月

傷病名　　診療実日数

初診	初診	回	点	入院	入院年月日　年　月　日		
	時間外	回	点		病 診	入院基本料・加算	
	休日	回	点			× 日間	点
	深夜	回	点			× 日間	点
再診	再診	回	点			× 日間	点
	外来管理加算	回	点			× 日間	点
	時間外	回	点			× 日間	点
	休日	回	点				
	深夜	回	点			特定入院料・その他	
医学管理			点	食事生活	基準	円 × 回	
在宅			点		特別	円 × 回	
					食事	円 × 回	
					環境	円 × 回	
投薬	内服	単	点	基準(生)	円 × 回		
	屯服	単	点	特別(生)	円 × 回		
	外用	単	点	減・免・猶・Ⅰ・Ⅱ・3月			
	処方	回	点				
	麻毒	回	点				
	調基		点				
注射	皮下筋肉内	回	点				
	静脈内	回	点				
	その他	回	点				
処置	処置	回	点				
手術麻酔	手術	回	点				
	麻酔	回	点				
検査	検査・病理	回	点				
画像診断		回	点				
その他		回	点	合計	円		

上記のとおり領収(診療)しました。　令和　年　月　日

医療機関所在地

医療機関の名称

医師の氏名

医療機関電話番号　(　)