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: 2000 / Number: ○○○○		Company	株式会社　セールスフォース・ジャパン
	Full Name	Furigana: ケンポ　タロウ 健保　太郎		Date of birth	Showa　60 / 4 / 30
	Address, telephone number, etc. (daytime phone number)	Postal code 123-4567 東京都　○○区　××　1-2-3		Phone number	090 （1234） 5678
	Employee ID	123456		Email	XXXX@gmail.com

Application details	Person undergoing medical treatment (circle the applicable person)	Insured person / Family member (dependent)	Name of person undergoing medical treatment	健保　太郎
	Name of injury / illness	インフルエンザ	Date of birth of person undergoing medical treatment	Showa　60 / 4 / 30
	Cause and reason of symptoms	高熱のため、急遽旅行先の病院で受診した。		
	Name of hospital where examination was conducted	○○医院	Address of hospital where examination was conducted	福岡県○○市○○町○－○-○
	Period during which medical treatment was conducted	From Reiwa 5/4/1 to Reiwa 5/4/1 — 1 days	If hospitalized during the period listed on the left, the period of hospitalization	From Reiwa (Year) / (Month) / (Day) to Reiwa (Year) / (Month) / (Day) — days
	Cost of medical care	7900 yen	Content of treatment	診察および投薬を受けた
	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。

If you are unable to attach the certificate of medical renumeration, please ask the medical institution for an itemized medical treatment receipt.

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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　　　（　　　　　）