

被保険者 療養費支給申請書 (立替払い・治療用器具等)
被扶養者

Insurance Card Code/Number		記号 〇〇〇〇		Name of Insured parson John Smith	
Employed Company Name and Phone 〇〇〇, Inc. (所属) 〇〇〇 Department phone 〇〇(〇〇〇〇)〇〇〇〇 (内線) 〇〇〇		Date of birth 昭和 15 年 10 月 20 日 平成 令和		relationship Eldest son	
Fill in when the target person is a dependent. name Michael Smith		Date of Birth 昭和 平成 令和			
Name of injury or illness Bone fracture in upper-left arm		Date injury or illness first occurred 令和 2 年 5 月 10 日			
Cause of injury or illness Tripped and fell on a hilly road. Treated at a hospital near to where the injury occurred.		Contents of medical treatment or equipment, etc. <input type="checkbox"/> 診療・投薬 <input checked="" type="checkbox"/> 治療用器具等の <input type="checkbox"/> その他()		<input type="checkbox"/> Medical consultation/Medicine <input type="checkbox"/> Purchase of equipment <input type="checkbox"/> Other (Please specify)	
Course of injury and illness <input checked="" type="checkbox"/> 順調 <input type="checkbox"/> 治癒 <input type="checkbox"/> 治療中 <input type="checkbox"/> その他		<input type="checkbox"/> Improving Satisfactorily <input type="checkbox"/> Cured/Recovered <input type="checkbox"/> In treatment <input type="checkbox"/> Other			
Medical institution name Rakuten clinic Address 1-14-1 Tamagawa, Setagaya-ku, Tokyo		Doctor's name (氏名) Dr. Taro Rakuten			
Total Cost 10,000 円		Receipt date 令和 2 年 5 月 21 日			
Treatment period (benefit period) from 2 年 5 月 10 日 to 和 2 年 5 月 21 日 日間		In case of hospitalization: Period of hospitalization 至 令和 年 月 日 (日間)			
In the case of orthoses: Date of installation 年 5 月 21 日		保険証交付年月日 令和 年 月 日			
Reason <input checked="" type="checkbox"/> 治療用必 <input type="checkbox"/> 保険証発行		<input type="checkbox"/> I have not received my insured card <input type="checkbox"/> Due to urgency, I went to hospital without possession of my insurance card <input type="checkbox"/> Reason for payment of medical benefit <input type="checkbox"/> Other (Please specify)			
Was it caused by the actions of a third party? / No 第三者の行為によって負傷したものか否か ある ・ ない					
Application date 和 年 月 日					
Insured person name(Self-signed) James Smith		Self-signed			
Bank name 〇〇〇〇 銀行 〇〇〇〇 本店 〇〇〇〇 支店		Branch name 本店: head office 支店: Branch office			
金融機関コード() 店番号 ()					
Deposit type 普通・当座		Account number 〇〇〇〇			
フリガナ					
口座名義 ※被保険者名義		James Smith			
		Pay to Account (In the name of the insured person)			

【Attached document】
Advance payment: Medical fee statement (original) , receipt (original) issued by medical institutions, etc.
Treatment equipment: Detailed receipt (original) , doctor's opinion (original)
Therapeutic glasses: Receipt (original) , doctor's instructions (original)

健保記入欄	法定給付	円	備考
	支給額	円	
	付加給付	円	
	合計	円	