Email submissions not accepted.

Claim for Medical Expenses（ (Y) 年 (M) 月分）（For acupuncture and moxibustion）

Column to be filled out by the insured person (employee)

Insurance Code - Number	Global ID	Date injury or illness first occurred	Cause of illness or injury
—		年(Y) 月(M) 日(D)	

Name of person who received the medical treatment	(Furigana)	Male - Female	Relationship with the insured	Was the need for medical care caused by to work or a third party?
				1. Work-related accidents 2. Third party 3. Other ※If 1 or 2, please contact AIG Health Insurance Association in advance.
	年(Y) 月(M) 日(D)			The place where the medical treatment was performed

Treatment details column

初療年月日	施術期間	実日数	請求区分
年 月 日	自・ 年 月 日～至・ 年 月 日	日	新規・継続
傷病名 1．神経痛 2．リウマチ 3．頸腕症候群 4．五十肩			転帰
5．腰痛症 6．頸椎捻挫後遺症 7．その他（ ）			継続・治癒・中止・転医

初検料 1はり 2きゅう 3はりきゅう併用			円	摘要
施術料	はり・きゅう	施術の種類	1術 回	2術 回
	通所	円×	回＝	円
	訪問施術料 1	円×	回＝	円
	訪問施術料 2	円×	回＝	円
	訪問施術料 3（3人～9人）	円×	回＝	円
	訪問施術料 3（10人以上）	円×	回＝	円
	電療料（加算／ 1電気針 2電気温灸器 3電気光線器具）	円×	回＝	円
	特別地域（加算）	円×	回＝	円
往療料		円×	回＝	円
施術報告書交付料（前回支給： 年 月分）		円×	回＝	円
費用額計				円

施術日 訪問1① 通所○ 訪問2② 往療◎ 訪問3③	月	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

往療又は訪問の理由 1．独歩による公共交通機関を使っての外出困難 2．認知症や視覚、内部、精神障害などにより独歩による外出困難 3．その他（ ）

Treatment certificate column

上記のとおり施術を行い、その費用を領収しました。

年 月 日

保健所登録区分 1.施術所所在地 2.出張専門施術者住所地

免許登録番号 はり師 住所

免許登録番号 きゅう師 氏名 電話

Application column

I claim the benefits in this case as described above.

In the case of an insured person in employment, the recipient of the Benefit shall be entrusted to the employer. (※)

年(Y) 月(M) 日(D)

To the Chairman of the AIG Health Insurance Association

Address of the insured

Full name of the insured

Daytime contact

(*)The deadline for this application is the 15th of every month. It will be paid together with the next month's salary.
(In the case of voluntary and continuously insured persons, transfer to the registered account on the 20th of the following month)

Consent record

同意医師の氏名	住所	同意年月日	傷病名	要加療期間
		年 月 日		

Acceptance stamp

***Please fill out this claim form and submit it with the following documents.**

(1)Receipt with details of treatment（original）※Cash register receipts will not be accepted.

(2)At the time of the initial application and every 6 months if treatment is continued Doctor's consent form (original)
*** Re-consent cannot be obtained verbally.**

(3)If you have been provided with a treatment report by the practitioner, a copy of it.

(4)If more than one year has passed since the date of first medical care and the number of treatments is 16 or more in a month, please fill out the "Reason for continuing treatment/condition entry form"

【Submission destination】Please submit to the Human Resource Partners (Labor & Social Security Attorneys Office)
Address: 19th floor, IMP Building, 1-3-7 Shiromi, Chuo-ku, Osaka-shi, 540-6319 Japan
Team for AIG , Human Resource Partners (Labor & Social Security Attorneys Office)

***If you are a voluntary and continuously insured persons, please send the claim form directly to AIG Health Insurance Association.**

Ⅰ）Filled out by the insured
①Column to be filled out by the insured person (employee)
②Application column
Ⅱ）Filled out by practitioner
①Treatment details column ② Treatment certificate column
③ Consent record

2025/4