Email submissions not accepted.

(Y) (M)

Claim for Medical Expenses（令和6 年 10 月分）（For Massages）

Example of entry

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
1 — 12345	1234567	令和4年(Y) 2月(M) 3日(D)	脳梗塞・左片麻痺・麻痺残存

Name of person who received the medical treatment		Relationship with the insured	Was the need for medical care caused by to work or a third party?
(Furigana) コウセイ ハルオ			1. Work-related accidents 2. Third party 3 Other ※If 1 or 2, please contact AIG Health Insurance Association in advance
厚生 春雄	Male ・ Female	本人	The place where the medical treatment was performed
平成〇〇年(Y) △△ 月(M) □□ 日(D)			

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
傷病名及び症状			転帰
			継続・治癒・中止・転医

施術料	同意部位	（躯幹）	（右上肢）	（左上肢）	（右下肢）	（左下肢）	摘要
マッサージ（施術料）	施術回数	回	回	回	回	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				
温罨法（加算）	円×	回＝	円				
温罨法・電気光線器具（加算）	円×	回＝	円				
変形徒手矯正術（加算）※温罨法との併施は不可	同意部位	（右上肢）	（左上肢）	（右下肢）	（左下肢）		
	施術回数	回	回	回	回		
	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				
合計			円				

Treatment details column and Treatment certificate column are filled out by the practitioner.

施術日	訪問１①	月	1	2	3	4	5	6	7	…	21	22	23	24	25	26	27	28	29	30	31
通所〇	訪問２②																				
往療◎	訪問３③																				

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 （ ）

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

住 所

免許登録番号

あん摩マッサージ指圧師

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. (※)

令和6 年(Y) 11 月(M) 1 日(D)

To the Chairman of the AIG Health Insurance Association

Address of the insured 〒000-0000 東京都墨田区錦糸〇－△－□

Full name of the insured 厚生 春雄

Daytime contact 03－〇〇〇〇－〇〇〇〇

(*)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
		月 日		

Consent record is filled out by the practitioner.

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.

However, in the case of a doctor's consent form stating that correction of structural deformities surgery is required, it must be submitted every month.

(3)A copy of the treatment report if it was issued by the practitioner

(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 ②Treatment certificate column
③Consent record

2025/4