For additional support

Ministry of Health, Labour and Welfare Hiroshima Prefecture

Procedures concerning the Medical Expense Support Program for Overseas Atomic Bomb Survivors

Additional support will be made available by taking the procedure described below, to persons who received support in medical expenses by this program from 2004 to 2013, and who have made copayment for medical expenses exceeding the ceiling in each year.

A special rule is applied to persons who live in South America, that no additional support in insurance premium is available, if they selected premium for private medical insurance, instead of medical expenses, as the basis for support. Nevertheless, such persons can also apply for additional support, if their copayment exceeded the ceiling in each year. This is because no other supports were available in the past to persons whose copayment have exceeded the ceiling.

In 2014 onward, support remains only available up to the ceiling for insurance premium for private medical insurance. Please also note that application can only be filed either for medical expenses or for insurance premium. Select whichever better suits your conditions before filing an application.

- 1. Please submit the documents listed in (1) through (5) below:
- (1) Application for Support (Forms 1 and 2)
 Enter necessary information into the forms provided on pages 3 and 4.
 (Note) See "Reference" on the final page for the ceiling for each year.
- (2) Attending Physician's /Dentist's Statement (Forms 3 to 7) Submit the forms provided on pages 5 to 14, as necessary, to the medical or dental institution where you were treated. Ask the institution to enter the treatments provided, itemized medical and other expenses, and other details for each year and for inpatient, outpatient, medical, and dental treatments. Review will be undertaken based on information provided in these forms. With respect to treatments provided for diseases certified as atomic bomb injuries, please tell the names of such diseases to the institution, and present either Form 6 or 7 for separate indication from other diseases.

(Note 1) The form(s) should be submitted for each year.

(Note 2) See the following website for diseases certified as atomic bomb injuries:

English: http://www.mhlw.go.jp/bunya/kenkou/genbaku04/dl/english.pdf

Portuguese: http://www.mhlw.go.jp/bunya/kenkou/genbaku04/dl/portuguese.pdf

- (3) Certificate of benefit payments
 If there have been benefits received from public insurance, etc. that should be deducted from medical expenses, attach materials that indicate the amount thereof.
 - (Note 1) In cases where the relevant amount is indicated in the Attending Physician's/Dentist's Statement in (2) above, this certificate needs not to be submitted.
 - (Note 2) The form(s) should be submitted for each year.
- (4) A copy of bankbook or other document that verifies your receiving account
- (5) A copy of certificate of atomic bomb injuries, if any
- 2. Please submit the documents listed under "1. (1) to (5)" to the following address by post. The documents must arrive no later than Friday, October 31, 2014.

As long as you have collected necessary documents, you may file the application in several separate portions for different years.

Review will be conducted for each year. If additional support is determined as applicable, payment will be completed by March 31, 2015. If you change your receiving account by that time, please be sure to notify us thereof.

3. Before sending the documents, please confirm that all the necessary documents have been prepared, using the Checklist of Documents to be Submitted on page 18.

[Send the documents to:]

1-29-8 Shinjuku, Shinjuku-ku, Tokyo, 160-0022 JAPAN

Section in charge of the Medical Expense Support Program for Overseas Atomic Bomb Survivors, Japan Public Health Association

Inquiries:

Hosoda, Japan Public Health Association

Telephone: +81-3-3352-4281 Fax: +81-3-3352-4605 E-mail: zaigai@jpha.or.jp

Application for Support

Support a	availability notification no.			_					
In katakana		Date	e of b	irth:					Sex
Name				/		/		N	M/F
Country of residence									
Address									
Telephone number	(include the country code)								
Fax/E-mail									
	Financial institution Name of head/branch office (*1)								
Receiving account	Address of head/branch office (*2)								
	Account no. (*3)								
	Account holder (*4)								
Any certified atomic	bomb injuries (*5)				Yes	/ No			
Any benefits receive	d (*6)				Yes	/ No			
Amount of	In local currency	(c	urren	cy) (* Lea	ive th	is fie	ld bl	ank)
application	In Japanese yen	yen (c	urren	cy) (* Lea	ive th	is fie	ld bl	ank)

As specified above, I apply for support in health and medical expenses paid in 2004 to 2013, with the submission of necessary documents.

Date:	/	/		
			Name of applicant:	(seal or signature)
(In the case of	of application by	agent) Name of a	gent:	

Contact information of agent:

* Accessible contact information must be provided for application by agent.

To: Governor of Prefecture

^{*1.} Be sure to enter the name of the head or branch office.

^{*2.} Be sure to enter the address.

^{*3.} Attach a copy of bankbook or other document that verifies your receiving account.

^{*4.} The account holder must be the applicant himself/herself.

^{*5.} If you have any certified atomic bomb injuries at the time of application, circle "Yes".

^{*6.} If you are receiving benefits for health management, benefits for health, special benefits for medical care, special benefits, and/or benefits for A-bomb microcephaly, circle "Yes".

Specification of Application by Year

Year	Medical expenses paid (1)	Insurance benefits, etc. (2)	Copayment (3) ((1) - (2))	Remarks
2004				
2005				
2006				
2007				
2008				
2009				
2010				
2011				
2012				
2013				
Total				

- (Note 1) Under "Medical expenses paid", indicate the overall amount that you have paid as medical expenses, after submitting a separate form to the medical/dental institution and have them enter itemized treatments, medical and other expenses, and other details for each year.
- (Note 2) Under "Insurance benefits, etc.", indicate the amount of insurance benefits, etc. that you have received on the relevant medical care, based on the certificated issued by the insurance company, etc.
- (Note 3) Under "Copayment", indicate the amount of medical expenses paid minus insurance benefits, etc.
- (Note 4) All the monetary amounts should be indicated in the local currency of your country of residence.

Outpatient

Sex

- (1) This form is used for applying for a support program in Japan (Medical Expense Support Program for Overseas Atomic Bomb Survivors).
- $(2) \ \underline{\text{The attending physician/dentist is requested to enter the treatments provided to the patient } \underline{\text{and sign this form}}.$

(The institution/physician may be contacted later for inquiry.)

- (3) This form is for Outpatient use. In principle, one sheet each of this form should be prepared for every year from 2004 to 2013.
 - * In principle, one sheet should cover one year from January to December of every year. (The sheet for 2004 should cover from October to December.)
 - $\ensuremath{^{*}}$ In patient treatments should be entered into the Inpatient form.

Name of patient

(1)

- * In the case where the patient requests indication of treatments related to diseases certified as atomic bomb injuries, please use a separate dedicated form.
- * While other forms are acceptable as long as the same items are indicated as in this form, the itemized receipt field and the signature field are indispensable.
- (4) Under "*9. Others", enter whatever information that is not provided in 1 through 8.

Attending Physician's Statement (<u>for year</u>)

International Classification of Diseases No. (ICD 10)

Date of birth

Primary illness or injury	(2)			International Classification	of Diseas	es No. (I	CD 10)					
or mjury	(3)			International Classification	of Disease	es No. (I	CD 10)					
	(1)											
Overview of treatment	(2)											
	(3)											
			Dani			1						
1. Visits			Desc	cription of treatments p	rovided	1						
	Primary illnes	s or iniu	rv		Pe	riod of	treatm	ent				Days
(1)			-5	From 20	/	/	to	20	/	/		- 10,00
(2)				From 20	/	/	to	20	/	/		
(3)				From 20	/	/	to	20	/	/		
(-)												
	An	nual tota	al days of treatmen	t $((1) + (2) + (3))$							da	ays
2. Medication	A	gent use	ed	Dosage			Dose			Tota	l days of	administratio
☐ Yes	_					_						days
	_					_						days
□ No	_			-		-						days
	_					_			_			days
	ermic / intramu	scular	☐ Intravenous	☐ Intravenous drip			Total	dare o	fodm	iniate	otion	dovo
	nt used: ermic / intramu	scular	☐ Intravenous	Amount used:		_	Total	days o	adm	mstra	mon:	days
	nt used:	scarar	_ marvenous	Amount used:			Total	days o	f adm	inistra	ation:	days
☐ Hypode	ermic / intramu	scular	☐ Intravenous	☐ Intravenous drip		_						
Agen	nt used:			Amount used:		_	Total	days o	f adm	inistra	ation:	days
4. Examination ☐ Urine		Des	cription	Agent used		_	Annual a	mount ad	minister	ed	Annual	times of test
☐ Blood	cardiography			_		_						time
☐ Ultrason		-		_		_						time time
	ther than the at	oove		_		-				•		time
		_				- -				•		time

hysiotherapy				
iysiomerapy		Annual times of treatment		time
adiography	Region	Agent used	Annual amount administered	Annual times of test
□ X-ray □	CT			time
	CT			time
,	CT CT		-	time
				time
ırgical operation (use a	separate form for inpatient surg	•		
	Description	n of operation (provide an overview)		
-				
Surg	geon fee Other expense	es Total expenses		
ther procedures (use a se	eparate form for inpatient proce	edures)		
	Description	n of procedure (provide an overview)		
		1		
-				
-				
-				
1				
Expenses	on procedure Expenses on mat	terials Other expenses	Total expenses	
Expenses Others Fee for issuing a m		terials Other expenses	Total expenses	
Others	nedical certificate	⇒ Major items	Total expenses	
Others ☐ Fee for issuing a m	nedical certificate		Total expenses	
Others ☐ Fee for issuing a m	nedical certificate enses Itu	⇒ Major items emized Receipt Not covered by insurance	Total	
Others ☐ Fee for issuing a m ☐ Total of other expe	nedical certificate	⇒ Major items emized Receipt Not covered by insurance (2)	Total (3)	
Others ☐ Fee for issuing a m ☐ Total of other expe	covered by insurance (1) (4)	⇒ Major items emized Receipt Not covered by insurance (2) (5)	Total (3) (6)	
Others ☐ Fee for issuing a m ☐ Total of other expe	nedical certificate	⇒ Major items emized Receipt Not covered by insurance (2)	Total (3)	
Dithers Fee for issuing a m Total of other expe Medical expenses Coverage by public insurance	Covered by insurance (1) e (4) (7)	⇒ Major items emized Receipt Not covered by insurance (2) (5)	Total (3) (6)	
Dithers Fee for issuing a m Total of other expe Medical expenses Coverage by public insurance Copayment	Covered by insurance (1) e (4) (7)	⇒ Major items emized Receipt Not covered by insurance (2) (5)	Total (3) (6)	
Dithers Fee for issuing a magnetic form of the expenses Medical expenses Coverage by public insurance Copayment Total amount received Remarks	Covered by insurance (1) (1) (10) (11)	⇒ Major items emized Receipt Not covered by insurance (2) (5)	Total (3) (6) (9)	ending Physician's /
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Dethers Fee for issuing a magnetic form of the expension	Covered by insurance (1) (4) (7) (10) (11) medical expenses that are covered bove. medical expenses that are not cover	⇒ Major items emized Receipt Not covered by insurance (2) (5) (8)	Total (3) (6) (9)	
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Dithers Fee for issuing a management of the property of the p	Covered by insurance (1) (4) (7) (10) (11) medical expenses that are covered by ove. medical expenses that are not cover ove. umount covered by public insurance umount of portion paid by the patien	⇒ Major items mized Receipt Not covered by insurance (2) (5) (8) by public insurance, among other medical red by public insurance, among other medical expenses that are covere ledical expenses that are not covered by public insurance of the medical expenses that are not covered by public insurance.	Total (3) (6) (9) expenses indicated in the Attectal expenses indicated in the attention in the atten	
Deters Fee for issuing a management of the problem of the expenses Coverage by public insurance Copayment Total amount received Remarks * In Field (1), enter the reportist's Statement about the problem of the pro	Covered by insurance (1) (4) (7) (10) (11) medical expenses that are covered by ove. medical expenses that are not cover ove. unount covered by public insurance unount of portion paid by the patient unount billed by the institution an amount billed by the institution an	⇒ Major items mized Receipt Not covered by insurance (2) (5) (8) by public insurance, among other medical red by public insurance, among other medical expenses that are covere ledical expenses that are not covered by public insurance of the medical expenses that are not covered by public insurance.	Total (3) (6) (9) expenses indicated in the Atte cal expenses indicated in the d by public insurance.	
Dithers Fee for issuing a magnetic field (1), enter the politic field (2), enter the politic field (3), enter the aliance in Field (4), enter the aliance in Field (5), enter the aliance in Field (8), enter the aliance in Field (8), enter the aliance in Field (10), enter the aliance in Field (10), enter the aliance in Field (11), describe	Covered by insurance (1) (1) (2) (3) (4) (7) (4) (10) (11) (11) (11) (11) (11) (11) (11) (11) (11) (11) (11) (11) (12) (13) (14) (15) (16) (17) (18) (19) (19) (19) (10) (11) (11) (11) (11) (12) (13) (14) (15) (16) (17) (18) (19	mized Receipt Not covered by insurance (2) (5) (8) by public insurance, among other medical red by public insurance, among other medical red by public insurance, among other medical expenses that are covere redical expenses that are not covered by public directived from the patient. 2) and (8), or those in (9) and (10), do not	Total (3) (6) (9) expenses indicated in the Atte cal expenses indicated in the d by public insurance.	
Dithers Fee for issuing a magnetic process. Medical expenses. Coverage by public insurance. Copayment. Total amount received. Remarks. * In Field (1), enter the magnetic process. In Field (2), enter the magnetic process. In Field (4), enter the magnetic process. * In Field (7), enter the magnetic process. * In Field (10), enter the magnetic process. * In Field (10), enter the magnetic process. * In Field (10), enter the magnetic process. * In Field (11), describe. * In Field (11), describe. * In Field (11), describe.	Covered by insurance (1) (4) (7) (10) (11) medical expenses that are covered by ove. medical expenses that are not cover ove. umount covered by public insurance umount of portion paid by the patient unount paid by the patient in the m amount billed by the institution an the reason in case that figures in (2) of attending physicial	mized Receipt Not covered by insurance (2) (5) (8) by public insurance, among other medical red by public insurance, among other medical exe among other medical exe and in the medical expenses that are covere ledical expenses that are not covered by public received from the patient. 2) and (8), or those in (9) and (10), do not	Total (3) (6) (9) expenses indicated in the Atte cal expenses indicated in the d by public insurance. iblic insurance.	Attending Physician
Dithers Fee for issuing a management of the service of the servic	Covered by insurance (1) (4) (7) (10) (11) medical expenses that are covered by ove. medical expenses that are not cover ove. mount covered by public insurance amount of portion paid by the patient in the mamount bailed by the institution an the reason in case that figures in (2) of attending physicians.	mized Receipt Not covered by insurance (2) (5) (8) by public insurance, among other medical red by public insurance, among other medical red by public insurance, among other medical expenses that are covere redical expenses that are not covered by public directived from the patient. 2) and (8), or those in (9) and (10), do not	Total (3) (6) (9) expenses indicated in the Attectal expenses indicated in the ad by public insurance. Total (a) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	Attending Physician
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Inpatient (Medical / Dental)

- (1) This form is used for applying for a support program in Japan (Medical Expense Support Program for Overseas Atomic Bomb Survivors).
- (2) The attending physician/dentist is requested to enter the treatments provided to the patient and sign this form. (The institution/physician may be contacted later for inquiry.)
- (3) This form is for Inpatient use. In principle, one sheet each of this form should be prepared for every year from 2004 to 2013.
 - * In principle, one sheet should cover one year from January to December of every year. (The sheet for 2004 should cover from October to December.)
 - * Outpatient treatments should be entered into the Outpatient form.
 - * In the case where the patient requests indication of treatments related to diseases certified as atomic bomb injuries, please use a separate dedicated form.
 - * While other forms are acceptable as long as the same items are indicated as in this form, the itemized receipt field and the signature field are indispensable.
- (4) Under "*9. Others", enter whatever information that is not provided in 1 through 8.

Attending Physician's Statement (<u>for year</u>)

Name of patient				Date of birth						Sex				
Primary illness or	(1)			International Classifica	ation of E	Diseases	No. (I	CD 10)			I			
injury that resulted in hospitalization	(2)			International Classifica	ation of E	Diseases	No. (I	CD 10)						
	(1)			<u>I</u>				I						
Overview of														
treatment	(2)													
			Desc	cription of treatmer	its prov	rided								
1. Hospitalization	1													
		nat resulted	in hospitalization	Period of hospitalizati	on (up to	two se	eparate	hospital	izations	can be	entered on	this sheet	Day	ys
(1)				From 2	20	/	/	to	20	/	/			
(2)				From 2	20	/	/	to	20	/	/			
2. Medication		Agent use	ed	Dosage				Dose			Total da	ys of ac	lministr	ation
☐ Yes													days	
													days	
□ No				-									days	
				-									days	
3. Injection														
☐ Hypode	rmic / intra	muscular	☐ Intravenous	☐ Intravenous d	rip									
Agen	t used:			Amount used:				Total	days o	f adm	inistratio	n:	days	
☐ Hypode	rmic / intra	muscular	□ Intravenous	☐ Intravenous d	rip									
Agen	t used:			Amount used:				Total	days o	f adm	inistratio	n:	days	
☐ Hypode	rmic / intra	muscular	\square Intravenous	☐ Intravenous d	rip									
Agen	t used:			Amount used:				Total	days o	f adm	inistratio	n:	days	
☐ Hypode	rmic / intra	muscular	☐ Intravenous	☐ Intravenous d	rip									
Agen	t used:			Amount used:				Total	days o	f adm	inistratio	n:	days	
4. Examination		Des	scription	Agent used				Annual a	mount ad	lminister	ed An	nual tir	nes of te	est
☐ Urine													1	times
\square Blood													1	times
☐ Electroc	cardiograph	y		_									1	times
☐ Ultrason	nography			_									1	times
☐ Tests of	her than the	above											t	times
		_		_									t	times
5. Physiotherapy														
				Annual tim	es of tr	eatme	nt	-					1	times
6. Radiography			Region	Agen	t used				Annual a	mount ac	lministered	Annu	al times of	f test
☐ X-ray	/ 	CT	-	5									t	times
□ X-ray		CT												times
☐ X-ray		CT	-									-		times
☐ X-ray		CT						-				-		times
								-						

edica	and address of al institution: Last						Medica		d no.: Title:	
		or attend	ing physicia	n						
* In F * In F * In F	Field (7), enter the an Field (8), enter the an Field (10), enter the a Field (11), describe th	nount of porti nount paid by amount billed the reason in ca	on paid by the patient the patient in the m by the institution an ase that figures in (2	nt in the nedical ex ad receive 2) and (8	ed from the patien	ot cove	red by public	insurance.	rance.	
* In F Der	Field (2), enter the mentist's Statement above Field (4), enter the an	edical expense ve.			iblic insurance, an	nong ot	her medical o	expenses in	dicated in the Atte	nding Physic
	Field (1), enter the mentist's Statement above	-	es that are covered b	by public	insurance, among	gother	medical expe	enses indica	ted in the Attendir	g Physician's
	Remarks	(11)								
Tota	al amount received	(10)		ı				1		
	Copayment	(7)		(8)			(9)		
	rage by public insurance	(4)			5)			(6)		
N.4	ledical expenses	(1)	ered by insurance	(Not covered	by ins	surance	(3)	Total	
		T		emiz	zed Recei					
	ee for issuing a me		cate		⇒ Majo	or item	s			
Others		·								
	(2)									
	Expenses o	n procedure	Expenses on mat	terials	Other expens	ses	Tot	al expense	s	
							1			
										_
(2) L	Description of proce	euure (provi	ue an overview)							
(2) E		- d (:	1							
(1) L		edure (provi	de all overview)							
	Description of proce	edure (provi	de an overvious)							
	rocaduras			<u> </u>						
(1)										
	Surgeon fee	e Ad	ministrative fee	N	Nursing fee	1	Meal payme	nt	Total expens	ses
(2) E	Description of opera	ation (provid	e an overview)							

Dental

- (1) This form is used for applying for a support program in Japan (Medical Expense Support Program for Overseas Atomic Bomb Survivors).
- (2) The attending physician/dentist is requested to enter the treatments provided to the patient and sign this form. (The institution/physician may be contacted later for inquiry.)
- (3) This form is for <u>Dental</u> use. In principle, <u>one sheet each of this form should be prepared for every year from 2004 to 2013.</u>
 - * In principle, one sheet should cover one year from January to December of every year. (The sheet for 2004 should cover from October to December.)
 - $\ensuremath{^{*}}$ In patient treatments should be entered into the Inpatient form.
- * While other forms are acceptable as long as the same items are indicated as in this form, the itemized receipt field and the signature field are indispensable.
- (4) Under "*14. Others", enter whatever information that is not provided in 1 through 13.

Attending Dentist's Statement (for year ____)

Name of patient				Date	of birth					Sex			
				Dei	ntal formu	la							
				Peri	manent tee	eth							
	#1 #2	#3 #4	#5 #6		#8 #9	#10	#11 =	#12 #1:	3 #14	#15 #	#16		
Right	8 7	6 5	4 3	2	1 1	2	3	4	5 6	7	8	Left	
	8 7	6 5	4 3		1 1	2	3		5 6		8		
	#32 #31	#30 #29	#28 #27	#26 #	#25 #24	#23	#22 1	#21 #2	0 #19	#18 +	#1/		
	Description of	treatments p	rovided			D	ental fo	rmula		A	Annua	l expenses	
1. Examination													
Date of first ex	amination												
Actual days wh	nen treatments v	were provide	ed										
Diagnostic fee	1												
Diagnostic fee	2												_
2. X-ray													
Bite-wing type													_
Standard type													_
Dental panorar	nic tomography	7											_
3. Medication													
□ Yes □	No												
Drug 1													
Drug 2													
Drug 3													_
4. Removal of dental	plaque												
Application of	agent Ye	es 🗆 No)										
Name of	agent												_
5. Scaling / root plan	ing												
Periodontal cur	rettage												_
Periodontal sur	gery												_
6. Tooth extraction													_
Other operation	ns												_
7. Pulp capping													
Pulpotomy													_
Root canal then	ару												_
	1												_
	2												_
	3					1			1				

Root canal

Des	cription of treatments provided	Dental formula	Fee
3. Filling			
Amalgam	1		
	2	_	
	3		
Resin	1	_	
	2		
	3	_	
9. Inlay / onlay		_	
10. Abutment construction	on with filler	_	_
Metal core			
Others			
11. Cap			
Porcelain / gold			
Silver alloy			
Others			
12. Bridge			
Abutment tooth			
Pontic			
13. Artificial tooth with a	root part	_	
Repair of artificial			
*14. Others (Specif	y any items other than the above)		
		_	
Dental certificate		-	

Itemized Receipt

	Covered by insurance	Not covered by insurance	Total
Medical expenses	(1)	(2)	(3)
Coverage by public insurance	(4)	(5)	(6)
Copayment	(7)	(8)	(9)
Total amount received	(10)		
Remarks	(11)		

^{*} In Field (1), enter the medical expenses that are covered by public insurance, among other medical expenses indicated in the Attending Physician's / Dentist's Statement above.

Name and address of atten	nding physician	
Medical institution:		Medical record no.:
Name: Last	First	Title:
Address: Hospital or clinic	2	Telephone no.:
Date:	Signature:	

^{*} In Field (2), enter the medical expenses that are not covered by public insurance, among other medical expenses indicated in the Attending Physician's / Dentist's Statement above.

 $^{\ ^{*}}$ In Field (4), enter the amount covered by public insurance.

^{*} In Field (7), enter the amount of portion paid by the patient in the medical expenses that are covered by public insurance.

^{*} In Field (8), enter the amount paid by the patient in the medical expenses that are not covered by public insurance.

^{*} In Field (10), enter the amount billed by the institution and received from the patient.

^{*} In Field (11), describe the reason in case that figures in (2) and (8), or those in (9) and (10), do not match.

Name of patient

Diseases Certified as Atomic Bomb Injuries (Outpatient)

Sex

- (1) This form is used for applying for a support program in Japan (Medical Expense Support Program for Overseas Atomic Bomb Survivors).
- (2) This form is for <u>Diseases Certified as Atomic Bomb Injuries (Outpatient)</u> use. In principle, <u>one sheet each of this form should be prepared</u> <u>for every year from 2004 to 2013.</u>
 - * In the case where the patient requests indication of treatments related to diseases certified as atomic bomb injuries, please use this form.
 - * Inpatient treatments should be entered into the Diseases Certified as Atomic Bomb Injuries (Inpatient) form.
 - * Treatments for diseases other than those certified as atomic bomb injuries should be entered into the relevant Inpatient or Outpatient form.
 - * In principle, one sheet should cover one year from January to December of every year. (The sheet for 2004 should cover from October to December.)
 - * While other forms are acceptable as long as the same items are indicated as in this form, the itemized receipt field and the signature field are indispensable.
- (3) The attending physician/dentist is requested to enter the treatments provided to the patient and sign this form. (The institution/physician may be contacted later for inquiry.)
- (4) Under "*9. Others", enter whatever information that is not provided in 1 through 8.

Attending Physician's Statement (<u>for year</u>)

Date of birth

	(1)		International Classification of	of Diseas	es No. (ICD 10)					
Primary illness or injury	(2)		International Classification of	of Diseas	es No. (ICD 10)					
or injury	(3)		International Classification of	of Diseas	es No. (ICD 10)					
	(1)		•				l				
	(2)										
Overview of	(2)										
treatment											
	(3)										
		Descr	ription of treatments p	orovid	ed						
1. Visits			1								
	Primary illness or inju	ry		Pe	riod o	f treatn	nent				Days
(1)			From 20	/	/	to	20	/	/		
(2)			From 20	/	/	to	20	/	/		
(3)			From 20	/	/	to	20	/	/		
			•								•
2. Medication			eatmen $((1) + (2) + (3))$	1		Dosa			Total c	day	
2. Medication ☐ Yes	Agent use	ed	Dosage			Dose			Total C	iays or a	dministrati
					_				_		days days
□ No	-				_				_		days
					_						days
3. Injection	-										
-	ermic / intramuscular	☐ Intravenous	☐ Intravenous drip								
Ager	nt used:		Amount used:		_	Total	days o	f adm	inistrati	on:	days
☐ Hypode	ermic / intramuscular	☐ Intravenous	☐ Intravenous drip								
Ager	nt used:	<u> </u>	Amount used:		_	Total	days o	f adm	inistrati	on:	days
		·	☐ Intravenous drip								
☐ Hypode	ermic / intramuscular	☐ Intravenous	□ Illitavenous urip								
	ermic / intramuscular nt used:	☐ Intravenous	Amount used:		_	Total	days o	f adm	inistrati	on:	days
	nt used:	Intravenous cription	-		_		days o				days mes of test
Agen 4. Examination Urine	nt used:		Amount used:								
Ager 4. Examination ☐ Urine ☐ Blood	Des		Amount used:		<u>-</u> -						mes of test
4. Examination Urine Blood Electron	Des		Amount used:		<u>-</u> - -						mes of test
4. Examination Urine Blood Electron	Des		Amount used:		<u>-</u> - - -						mes of test tin tin
4. Examination Urine Blood Electron	Des		Amount used:								mes of test tin tin

	Descripti	ion of treatments provided		
Physiotherapy		Annual times of treatment		time
Radiography □ X-ray □	Region	Agent used	Annual amount administered	Annual times of test
□ X-ray □				time
□ X-ray □	-	<u> </u>		time
□ X-ray □	CT		-	time
Jurgical operation (use a se	eparate form for inpatient surgery			
digical operation (use a se	1 0 1	operation (provide an overview)		
	Description of	operation (provide an overview)		
Surge	on fee Other expenses	Total expenses		
Other procedures (use a sep	parate form for inpatient procedur	es)		
	Description of p	procedure (provide an overview)		
-				
Evnonsos o	n procedure Expenses on materia	ls Other expenses To	otal expenses	
Expenses of	ii procedurej Expenses on materia	is other expenses if it	otal expenses	
			1	
Others			1	
Others				7
Others ☐ Fee for issuing a me				
	edical certificate	⇒ Major items	·	
☐ Fee for issuing a me	edical certificate		·	
☐ Fee for issuing a me	edical certificate			
☐ Fee for issuing a me	edical certificate			
☐ Fee for issuing a me	edical certificate	⇒ Major items	Total	
☐ Fee for issuing a me	edical certificate uses Iten	⇒ Major items mized Receipt		
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses	dical certificate Iten Covered by insurance (1)	⇒ Major items mized Receipt Not covered by insurance	Total	
☐ Fee for issuing a me ☐ Total of other expen Medical expenses Coverage by public insurance	dical certificate ses Iten Covered by insurance (1) (4)	⇒ Major items mized Receipt Not covered by insurance (2) (5)	Total (3) (6)	
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Copayment ☐ Copayment	Covered by insurance (1) (4) (7)	⇒ Major items mized Receipt Not covered by insurance (2)	Total (3)	
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received	Covered by insurance (1) (4) (7) (10)	⇒ Major items mized Receipt Not covered by insurance (2) (5)	Total (3) (6)	
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received ☐ Remarks	Covered by insurance (1) (4) (7) (10) (11)	⇒ Major items mized Receipt Not covered by insurance (2) (5) (8)	Total (3) (6) (9)	
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received ☐ Remarks * In Field (1), enter the me	Covered by insurance (1) (4) (7) (10) (11) edical expenses that are covered by pu	⇒ Major items mized Receipt Not covered by insurance (2) (5)	Total (3) (6) (9)	nding Physician's /
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received ☐ Remarks * In Field (1), enter the medentist's Statement above	Covered by insurance (1) (4) (7) (10) (11) edical expenses that are covered by pure.	⇒ Major items mized Receipt Not covered by insurance (2) (5) (8)	Total (3) (6) (9)	
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received ☐ Remarks * In Field (1), enter the medical pentist's Statement above ☐ In Field (2), enter the medical pentist's Statement above ☐ Dentist's Statement above	Covered by insurance (1) (4) (7) (10) (11) edical expenses that are covered by puze. edical expenses that are not covered by puze.	⇒ Major items nized Receipt Not covered by insurance (2) (5) (8)	Total (3) (6) (9)	
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received ☐ Remarks * In Field (1), enter the medical pentist's Statement abov ☐ In Field (2), enter the medical pentist's Statement abov ☐ In Field (4), enter the and	Covered by insurance (1) (4) (7) (10) (11) edical expenses that are covered by puzze. edical expenses that are not covered by zero. nount covered by public insurance.	⇒ Major items mized Receipt Not covered by insurance (2) (5) (8) ublic insurance, among other medical expression of the medical expression of	Total (3) (6) (9) penses indicated in the Atte	
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received ☐ Remarks * In Field (1), enter the medical pentist's Statement abov ☐ In Field (2), enter the medical pentist's Statement abov ☐ In Field (4), enter the an ☐ In Field (7), enter the an	Covered by insurance (1) (4) (7) (10) (11) edical expenses that are covered by prove. edical expenses that are not covered by pure. nount covered by public insurance. nount of portion paid by the patient in	⇒ Major items nized Receipt Not covered by insurance (2) (5) (8)	Total (3) (6) (9) penses indicated in the Atternal expenses in the Atternal expenses	
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received ☐ Remarks ☐ In Field (1), enter the medical book ☐ In Field (2), enter the medical book ☐ In Field (4), enter the an ☐ In Field (7), enter the an ☐ In Field (8), enter the an	Covered by insurance (1) (4) (7) (10) (11) edical expenses that are covered by prove. edical expenses that are not covered by pure. nount covered by public insurance. nount of portion paid by the patient in	⇒ Major items mized Receipt Not covered by insurance (2) (5) (8) ablic insurance, among other medical expenses that are covered by all expenses that are not covered by public insurance of the medical expenses that are not covered by public insurance.	Total (3) (6) (9) penses indicated in the Atternal expenses in the Atternal expenses	
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received ☐ Remarks * In Field (1), enter the medical book In Field (2), enter the medical book In Field (4), enter the an In Field (7), enter the an In Field (8), enter the an In Field (8), enter the an In Field (10), enter the an In Field (10), enter the an In Field (10), enter the an	Covered by insurance (1) (4) (7) (10) (11) edical expenses that are covered by proceedical expenses that are not covered by proceeding the proceeding that the procedure t	⇒ Major items mized Receipt Not covered by insurance (2) (5) (8) ablic insurance, among other medical expenses that are covered by all expenses that are not covered by public insurance of the medical expenses that are not covered by public insurance.	Total (3) (6) (9) penses indicated in the Atte l expenses indicated in the A	
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received ☐ Remarks * In Field (1), enter the medical pentist's Statement abov ☐ In Field (2), enter the an ☐ In Field (4), enter the an ☐ In Field (8), enter the an ☐ In Field (10), enter the an ☐ In Field (11), describe the	Covered by insurance (1) (4) (7) (10) (11) edical expenses that are covered by pure, edical expenses that are not covered by re, enount covered by public insurance, mount of portion paid by the patient in nount paid by the patient in the medic mount billed by the institution and reme reason in case that figures in (2) and	Not covered by insurance (2) (5) (8) ablic insurance, among other medical expenses that are covered by public eived from the patient.	Total (3) (6) (9) penses indicated in the Atte l expenses indicated in the A	
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received ☐ Remarks * In Field (1), enter the mount is the statement above In Field (2), enter the and In Field (4), enter the and In Field (7), enter the and In Field (10), enter the and In Field (10), enter the and In Field (11), describe the and In Field (12), enter the and In Field (13), enter the and In Field (14), enter the and In Field (15), enter the and In Field (16), enter the and In Field (17), enter the and In Field (18), enter the and In Field (19), enter the	Covered by insurance (1) (4) (7) (10) (11) edical expenses that are covered by pure. edical expenses that are not covered by pure. nount covered by public insurance. nount of portion paid by the patient in the medic amount billed by the institution and remainment in case that figures in (2) an area of attending physician	Major items Not covered by insurance (2) (5) (8) ublic insurance, among other medical expenses that are covered by all expenses that are covered by all expenses that are not covered by publiceived from the patient. d (8), or those in (9) and (10), do not mage	Total (3) (6) (9) penses indicated in the Atte Il expenses indicated in the A	Attending Physician
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received ☐ Remarks * In Field (1), enter the mount ist's Statement above In Field (2), enter the an In Field (4), enter the an In Field (7), enter the an In Field (10), enter the an In Field (11), describe the ☐ The control of	Covered by insurance (1) (4) (7) (10) (11) edical expenses that are covered by pure, edical expenses that are not covered by re, enount covered by public insurance, mount of portion paid by the patient in nount paid by the patient in the medic mount billed by the institution and reme reason in case that figures in (2) and	Major items Not covered by insurance (2) (5) (8) ublic insurance, among other medical expenses that are covered by all expenses that are covered by all expenses that are not covered by publiceived from the patient. d (8), or those in (9) and (10), do not mage	Total (3) (6) (9) penses indicated in the Atte Il expenses indicated in the Atte by public insurance. ic insurance. attch.	Attending Physician
☐ Fee for issuing a me ☐ Total of other expen ☐ Medical expenses ☐ Coverage by public insurance ☐ Copayment ☐ Total amount received ☐ Remarks * In Field (1), enter the mount ist's Statement above In Field (2), enter the an In Field (4), enter the an In Field (7), enter the an In Field (10), enter the an In Field (11), describe the ☐ The control of	Covered by insurance (1) (4) (7) (10) (11) edical expenses that are covered by pure. edical expenses that are not covered by pure. nount covered by public insurance. nount of portion paid by the patient in the medic amount billed by the institution and remainment in case that figures in (2) an area of attending physician	Major items Not covered by insurance (2) (5) (8) ublic insurance, among other medical expenses that are covered by all expenses that are covered by all expenses that are not covered by publiceived from the patient. d (8), or those in (9) and (10), do not mage	Total (3) (6) (9) penses indicated in the Atte Il expenses indicated in the Atte by public insurance. ic insurance. attch.	Attending Physician

Diseases Certified as Atomic Bomb Injuries (Inpatient)

- (1) This form is used for applying for a support program in Japan (Medical Expense Support Program for Overseas Atomic Bomb Survivors).
- (2) This form is for <u>Diseases Certified as Atomic Bomb Injuries (Inpatient)</u> use. In principle, <u>one sheet each of this form should be prepared</u> for every year from 2004 to 2013.
 - * In the case where the patient requests indication of treatments related to diseases certified as atomic bomb injuries, please use this form.
 - * Outpatient treatments should be entered into the Diseases Certified as Atomic Bomb Injuries (Outpatient) form.
 - * Treatments for diseases other than those certified as atomic bomb injuries should be entered into the relevant Inpatient or Outpatient form.
 - * In principle, one sheet should cover one year from January to December of every year. (The sheet for 2004 should cover from October to December.)
 - * While other forms are acceptable as long as the same items are indicated as in this form, the itemized receipt field and the signature field are indispensable
- $(3) \ \underline{\text{The attending physician/dentist is requested to enter}} \ \text{the treatments provided to the patient} \ \underline{\text{and sign this form}}.$

(The institution/physician may be contacted later for inquiry.)

(4) Under "*9. Others", enter whatever information that is not provided in 1 through 8.

Attending Physician's Statement (<u>for year</u>)

			-										
Name of patient				Date of birth					Sex				
	(1)			International Classifica	ation of Diseas	es No. (l	CD 10)						
injury that resulted in hospitalization	(2)			International Classification of Diseases No. (ICD 10)									
Overview of treatment	(2)												
			D			1							
1. Hospitalization	.		Desc	ription of treatmer	us provided	1							
		resulted i	n hospitalization	Period of hospitalizati	on (up to two	separate	hospital	izations	can be	entered	l on this	sheet)	Days
(1)			F	From		/	to	20	/	/			
(2)				From 2	20 /	/	to	20	/	/			
2. Medication	A	gent used	i	Dosage			Dose			Tota	l days	of admii	nistration
☐ Yes												da	ıys
	_											da	ıys
□ No						_				•		da	iys
	_					_						da	iys
Agen Hypode Agen Hypode Agen Hypode	rmic / intramus t used: rmic / intramus t used: rmic / intramus t used: rmic / intramus t used:	scular scular	☐ Intravenous ☐ Intravenous ☐ Intravenous ☐ Intravenous	☐ Intravenous of Amount used:	lrip Irip	- - -	Total Total Total Total	days o	f adm f adm	inistra	ation:	da da	ys ys ys
4. Examination		Desc	cription	Agent used			Annual a	mount ad	minister	red	Annua	al times	of test
☐ Urine				_		_							times
☐ Blood				_		_							times
	ardiography			_		_							times
☐ Ultrasor	nography her than the ab					_							times
□ Tests of	ner man me ao	oove		<u> </u>		-	-			•			times
- DI				-		_	-						times
5. Physiotherapy				Annual tim	es of treatn	nent	-						times
6. Radiography			Region	Agen	t used			Annual a	mount a	dministe	red	Annual tir	nes of test
☐ X-ray	′ □ C	T									_		times
☐ X-ray	′ □ C	T											times
☐ X-ray		T	-				_						times
☐ X-ray	′ □ C	T									-		times

		Dagarin	ation of trantments	wided			
rgical operation		Descrip	ption of treatments pro	ovided			
(1) Description of opera	ntion (provide an o	overview)					
(1) Bescription of opera	mon (provide an o	, , , , , , , , , , , , , , , , , , , ,					
(2) Description of opera	ation (provide an o	overview)					
(2) Bescription of opera	mon (provide an o	, , , , , , , , , , , , , , , , , , , ,					
Surgeon fee	Administ	trative fee	Nursing fee	Meal payme	ent	Total expenses	
(1)							
(2)							
ther procedures							
(1) Description of proce	dure (provide an o	overview)					
(2) Description of proce	edure (provide an o	overview)					
Expenses or	n procedure Expe	enses on mater	ials Other expens	es To	tal expenses		
Expenses of (1)	n procedure Expe	enses on mater	ials Other expens	es To	tal expenses		
	n procedure Expe	enses on mater	ials Other expens	es To	tal expenses		
(1)	n procedure Expe	enses on mater	ials Other expens	es To	tal expenses		
(1) (2)		enses on mater	ials Other expens	es To	tal expenses		
(1) (2) Others	dical certificate	enses on mater		r items	tal expenses		
(1) (2) Others	dical certificate	enses on mater			tal expenses		
(1) (2) Others	dical certificate		⇒ Majo	r items	tal expenses		
(1) (2) Others	dical certificate			r items	tal expenses		
(1) (2) Others	dical certificate ses	Ite	⇒ Majo	ritems	tal expenses	Total	
(1) (2) Others ☐ Fee for issuing a me ☐ Total of other expen	dical certificate ses		⇒ Majo	r items	(3)	Total	
(1) (2) Others ☐ Fee for issuing a me ☐ Total of other expen Medical expenses	dical certificate ses Covered by	Ite	⇒ Majo	ritems		Total	
(1) (2) Others Fee for issuing a me Total of other expen Medical expenses Coverage by public insurance	dical certificate ses Covered by	Ite	⇒ Majo mized Recei Not covered (2)	ritems	(3)	Total	
(1) (2) Others Fee for issuing a me Total of other expen Medical expenses Coverage by public insurance Copayment	dical certificate ses Covered by (1) (4) (7)	Ite	⇒ Majo mized Recei Not covered (2) (5)	ritems	(3)	Total	
(1) (2) Others Fee for issuing a me Total of other expen Medical expenses Coverage by public insurance Copayment Total amount received	dical certificate ses Covered by (1) (4) (7) (10)	Ite	⇒ Majo mized Recei Not covered (2) (5)	ritems	(3)	Total	
(1) (2) Others Fee for issuing a me Total of other expen Medical expenses Coverage by public insurance Copayment Total amount received Remarks	Covered by (1) (4) (7) (10) (11)	Ite.	⇒ Majo mized Recei Not covered (2) (5) (8)	pt by insurance	(3) (6) (9)		
(1) (2) Others Fee for issuing a me Total of other expen Medical expenses Coverage by public insurance Copayment Total amount received	Covered by (1) (4) (7) (10) (11) edical expenses that	Ite.	⇒ Majo mized Recei Not covered (2) (5) (8)	pt by insurance	(3) (6) (9)		ysician's
Medical expenses Coverage by public insurance Copayment Total amount received Remarks * In Field (1), enter the medical (2), enter the medical (2), enter the medical (2), enter the medical (2), enter the medical (3).	Covered by (1) (4) (7) (10) (11) edical expenses that re. edical expenses that	Ite:	⇒ Majo mized Recei Not covered (2) (5) (8)	pt by insurance	(3) (6) (9)	d in the Attending Ph	-
Medical expenses Coverage by public insurance Copayment Total amount received Remarks * In Field (1), enter the medical (2), enter the medical (2), enter the medical (2), enter the medical (2), enter the medical (3), enter the medical (4), enter t	Covered by (1) (4) (7) (10) (11) edical expenses that re. edical expenses that re.	Ite:	⇒ Majo mized Recei Not covered (2) (5) (8)	pt by insurance	(3) (6) (9)	d in the Attending Ph	-
Medical expenses Coverage by public insurance Copayment Total amount received Remarks * In Field (1), enter the medical (2), enter the medical (2), enter the medical (2), enter the medical (2), enter the medical (3).	Covered by (1) (4) (7) (10) (11) edical expenses that re. edical expenses that re. nount covered by pul	Ite: y insurance are covered by are not covered blic insurance.	⇒ Majo mized Recei Not covered (2) (5) (8) public insurance, among	pt by insurance other medical exp	(3) (6) (9) enses indicated expenses indicated expe	d in the Attending Ph	-
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Notice of Death

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Beneficiary wh	Address a time of d														
	Date of d														
	Attach a do Return the						eath.								

(Japanese Industrial Standards A4 Format)

Application for Support (Post-Mortem Application)

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Report of Change(s) (in Name, Address and/or Telephone Number)

Address after change:

To: Governor / Mayor of

Date:

		Name after change:					(se	al or	signa	ature)
I report the c	hange as specified below	, with the submission of	a cop	y of	the	supp	ort a	vaila	bility	7
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	In katakana									
Change of name	Name before change									
	In katakana									
	Name after change									
Change of	Address before change									
address	Address after change									
Change of telephone	Telephone number before change	(include the country co	de)							
number	Telephone number after change	(include the country co	de)							
Γ	Date of change	/				/				
* Attach doc	uments that verify the ch	ange(s) and that authenti	cate 1	the b	enef	iciar	y.			

(Japanese Industrial Standards A4 Format)

Checklist of Documents to be Submitted

*Before submitting the documents, please confirm that all the necessary documents have been prepared.

Check	Documents to be submitted
	Application for Support (Form 1)
	Specification of Application by Year (Form 2)
	Attending Physician's /Dentist's Statement (Forms 3 to 7) * The form(s) should be submitted for each year.
	Certificate of benefit payments *1. The certificate should be submitted for each year. *2. In cases where the relevant amount is indicated in the Attending Physician's /Dentist's Statement, and there are no other benefits to be deducted, this certificate needs not to be submitted.
	A copy of bankbook or other document that verifies your receiving account
	A copy of certificate of atomic bomb injuries, if any

(Reference)

1. Ceiling for each year

(in Japanese yen)

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Ordinary	32,500	130,000	130,000	130,000	145,000	153,000	161,000	171,000	176,000	179,000
Special (Hospital stay ≥ 4 days)	35,500	142,000	142,000	142,000	157,000	165,000	172,000	183,000	187,000	191,000

2. Diseases certified as atomic bomb injuries:

Illness or injury that was caused by radiation from A-bomb can be certified by the Minister of Health, Labour and Welfare. Typical diseases certified as atomic bomb injuries include 1) malignant tumor, 2) leukemia, and 3) hyperparathyroidism.