For additional support

Ministry of Health, Labour and Welfare
Hiroshima City and Nagasaki City

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.

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

Form No. 1

Application for Support

Support availability notification no.				–					
In katakana		Date of birth: / /							Sex
Name									M / F
Country of residence									
Address									
Telephone number	(include the country code)								
Fax/E-mail									
Receiving account	Financial institution								
	Name of head/branch office (*1)								
	Address of head/branch office (*2)								
	Account no. (*3)								
	Account holder (*4)								
Any certified atomic bomb injuries (*5)		Yes / No							
Any benefits received (*6)		Yes / No							
Amount of application	In local currency	(currency) (* Leave this field blank)							
	In Japanese yen	yen (currency) (* Leave this field blank)							

*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”.

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 application by agent) Name of agent:
Contact information of agent:

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

To: Governor of Prefecture

Form No. 2

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.

Ask the institution to complete this form.

Outpatient

(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 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.)
* Inpatient treatments should be entered into the Inpatient 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 (for year _____)

Name of patient		Date of birth		Sex	
Primary illness or injury	(1)	International Classification of Diseases No. (ICD 10)			
	(2)	International Classification of Diseases No. (ICD 10)			
	(3)	International Classification of Diseases No. (ICD 10)			
Overview of treatment	(1)				
	(2)				
	(3)				

Description of treatments provided

1. Visits

Primary illness or injury	Period of treatment	Days
(1)	From 20 / / to 20 / /	
(2)	From 20 / / to 20 / /	
(3)	From 20 / / to 20 / /	

Annual total days of treatment ((1) + (2) + (3)) _____ days

2. Medication

	Agent used	Dosage	Dose	Total days of administration
☐ Yes				days
				days
☐ No				days
				days

3. Injection

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

4. Examination

	Description	Agent used	Annual amount administered	Annual times of test
☐ Urine				times
☐ Blood				times
☐ Electrocardiography				times
☐ Ultrasonography				times
☐ Tests other than the above				times
				times

Description of treatments provided					
5. Physiotherapy					
			Annual times of treatment		times
6. Radiography		Region	Agent used	Annual amount administered	Annual times of test
☐ X-ray	☐ CT				times
☐ X-ray	☐ CT				times
☐ X-ray	☐ CT				times
☐ X-ray	☐ CT				times

7. Surgical operation (use a separate form for inpatient surgery)

Description of operation (provide an overview)

Surgeon fee	Other expenses	Total expenses

8. Other procedures (use a separate form for inpatient procedures)

Description of procedure (provide an overview)

Expenses on procedure	Expenses on materials	Other expenses	Total expenses

*9. Others

☐ Fee for issuing a medical certificate _____

☐ Total of other expenses _____ ⇒ Major items [ ]

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.
* 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 and address of attending physician

Medical institution: _____ **Medical record no.:** _____

Name: **Last** _____ **First** _____ **Title:** _____

Address: **Hospital or clinic** _____ **Telephone no.:** _____

Date: _____ **Signature:** _____

Ask the institution to complete this form.

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 (for year _____)

Name of patient		Date of birth		Sex	
Primary illness or injury that resulted in hospitalization	(1)	International Classification of Diseases No. (ICD 10)			
	(2)	International Classification of Diseases No. (ICD 10)			
Overview of treatment	(1)				
	(2)				

Description of treatments provided

1. Hospitalization

Primary illness or injury that resulted in hospitalization	Period of hospitalization (up to two separate hospitalizations can be entered on this sheet)	Days
(1)	From 20 / / to 20 / /	
(2)	From 20 / / to 20 / /	

2. Medication

	Agent used	Dosage	Dose	Total days of administration
☐ Yes				days
				days
☐ No				days
				days

3. Injection

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

4. Examination

	Description	Agent used	Annual amount administered	Annual times of test
☐ Urine				times
☐ Blood				times
☐ Electrocardiography				times
☐ Ultrasonography				times
☐ Tests other than the above				times
				times

5. Physiotherapy

Annual times of treatment _____ times

6. Radiography

		Region	Agent used	Annual amount administered	Annual times of test
☐ X-ray	☐ CT				times
☐ X-ray	☐ CT				times
☐ X-ray	☐ CT				times
☐ X-ray	☐ CT				times

Description of treatments provided

7. Surgical operation

(1) Description of operation (provide an overview)

(2) Description of operation (provide an overview)

	Surgeon fee	Administrative fee	Nursing fee	Meal payment	Total expenses
(1)					
(2)					

8. Other procedures

(1) Description of procedure (provide an overview)

(2) Description of procedure (provide an overview)

	Expenses on procedure	Expenses on materials	Other expenses	Total expenses
(1)				
(2)				

*9. Others

☐ Fee for issuing a medical certificate _____

☐ Total of other expenses _____ ⇒ Major items [ ]

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.
* 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 and address of attending physician

Medical institution: _____ **Medical record no.:** _____

Name: **Last** **First** **Title:** _____

Address: **Hospital or clinic** **Telephone no.:** _____

Date: _____ **Signature:** _____

Ask the institution to complete this form.

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 Dental 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.)
* Inpatient 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	

Dental formula

Permanent teeth

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12	#13	#14	#15	#16	
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
Right	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	Left
	#32	#31	#30	#29	#28	#27	#26	#25	#24	#23	#22	#21	#20	#19	#18	#17	

Description of treatments provided	Dental formula	Annual expenses
1. Examination Date of first examination _____ Actual days when treatments were provided _____ Diagnostic fee 1 _____ Diagnostic fee 2 _____		_____
2. X-ray Bite-wing type Standard type Dental panoramic tomography		_____ _____ _____
3. Medication ☐ Yes ☐ No Drug 1 Drug 2 Drug 3		_____
4. Removal of dental plaque Application of agent ☐ Yes ☐ No Name of agent _____		_____
5. Scaling / root planing Periodontal curettage Periodontal surgery		_____ _____ _____
6. Tooth extraction Other operations		_____ _____
7. Pulp capping Pulpotomy Root canal therapy 1 2 3 Root canal		_____ _____ _____ _____ _____ _____

Description of treatments provided	Dental formula	Fee
8. Filling		
Amalgam 1		
2		
3		
Resin 1		
2		
3		
9. Inlay / onlay		
10. Abutment construction 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 tooth		
*14. Others (Specify 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.
* 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 and address of attending physician

Medical institution: _____ **Medical record no.:** _____

Name: **Last** _____ **First** _____ **Title:** _____

Address: **Hospital or clinic** _____ **Telephone no.:** _____

Date: _____ **Signature:** _____

Ask the institution to complete this form.

Diseases Certified as Atomic Bomb Injuries (Outpatient)

(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 Diseases Certified as Atomic Bomb Injuries (Outpatient) use. In principle, one sheet each of this form should be prepared 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.
* 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 (for year _____)

Name of patient		Date of birth		Sex	
Primary illness or injury	(1)	International Classification of Diseases No. (ICD 10)			
	(2)	International Classification of Diseases No. (ICD 10)			
	(3)	International Classification of Diseases No. (ICD 10)			
Overview of treatment	(1)				
	(2)				
	(3)				

Description of treatments provided		
1. Visits		
Primary illness or injury	Period of treatment	Days
(1)	From 20 / / to 20 / /	
(2)	From 20 / / to 20 / /	
(3)	From 20 / / to 20 / /	
Annual total days of treatmen ((1) + (2) + (3))	_____ days	

2. Medication

	Agent used	Dosage	Dose	Total days of administration
☐ Yes				days
				days
☐ No				days
				days

3. Injection

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

4. Examination

	Description	Agent used	Annual amount administered	Annual times of test
☐ Urine				times
☐ Blood				times
☐ Electrocardiography				times
☐ Ultrasonography				times
☐ Tests other than the above				times
				times

Description of treatments provided					
5. Physiotherapy					
			Annual times of treatment		____ times
6. Radiography		Region	Agent used	Annual amount administered	Annual times of test
☐ X-ray	☐ CT				____ times
☐ X-ray	☐ CT				____ times
☐ X-ray	☐ CT				____ times
☐ X-ray	☐ CT				____ times

7. Surgical operation (use a separate form for inpatient surgery)

Description of operation (provide an overview)

Surgeon fee	Other expenses	Total expenses

8. Other procedures (use a separate form for inpatient procedures)

Description of procedure (provide an overview)

Expenses on procedure	Expenses on materials	Other expenses	Total expenses

*9. Others

☐ Fee for issuing a medical certificate ____

☐ Total of other expenses ____ ⇒ Major items [ ]

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.
* 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 and address of attending physician

Medical institution: ____ **Medical record no.:** ____

Name: **Last** **First** **Title:** ____

Address: **Hospital or clinic** **Telephone no.:** ____

Date: ____ **Signature:** ____

Ask the institution to complete this form.

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 Diseases Certified as Atomic Bomb Injuries (Inpatient) use. In principle, one sheet each of this form should be prepared 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) 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 (for year _____)

Name of patient		Date of birth		Sex	
Primary illness or injury that resulted in hospitalization	(1)	International Classification of Diseases No. (ICD 10)			
	(2)	International Classification of Diseases No. (ICD 10)			
Overview of treatment	(1)				
	(2)				

Description of treatments provided

1. Hospitalization

Primary illness or injury that resulted in hospitalization	Period of hospitalization (up to two separate hospitalizations can be entered on this sheet)	Days
(1)	From 20 / / to 20 / /	
(2)	From 20 / / to 20 / /	

2. Medication

	Agent used	Dosage	Dose	Total days of administration
☐ Yes				days
				days
☐ No				days
				days

3. Injection

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

☐ Hypodermic / intramuscular ☐ Intravenous ☐ Intravenous drip
Agent used: Amount used: Total days of administration: days

4. Examination

	Description	Agent used	Annual amount administered	Annual times of test
☐ Urine				times
☐ Blood				times
☐ Electrocardiography				times
☐ Ultrasonography				times
☐ Tests other than the above				times
				times

5. Physiotherapy

Annual times of treatment _____ times

6. Radiography

	Region	Agent used	Annual amount administered	Annual times of test
☐ X-ray ☐ CT				times
☐ X-ray ☐ CT				times
☐ X-ray ☐ CT				times
☐ X-ray ☐ CT				times

Description of treatments provided

7. Surgical operation

(1) Description of operation (provide an overview)

(2) Description of operation (provide an overview)

	Surgeon fee	Administrative fee	Nursing fee	Meal payment	Total expenses
(1)					
(2)					

8. Other procedures

(1) Description of procedure (provide an overview)

(2) Description of procedure (provide an overview)

	Expenses on procedure	Expenses on materials	Other expenses	Total expenses
(1)				
(2)				

*9. Others

☐ Fee for issuing a medical certificate _____

☐ Total of other expenses _____ ⇒ Major items [ ]

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.
* 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 and address of attending physician

Medical institution: _____ **Medical record no.:** _____

Name: **Last** _____ **First** _____ **Title:** _____

Address: **Hospital or clinic** _____ **Telephone no.:** _____

Date: _____ **Signature:** _____

Form No. 8

Notice of Death

Date: / /

To: Governor / Mayor of :

I report the death of the person specified below, with the submission of necessary documents.

(In katakana)		Relationship with the beneficiary who has died	
Name			
Country of residence			
Address			
Telephone number	(include the country code)		

Beneficiary who has died	Support availability notification no.				–					
	In katakana									
	Name									
	Address at the time of death									
	Date of death									

* Attach a document that verifies the date of death.
* Return the support availability notification.

(Japanese Industrial Standards A4 Format)

Form No. 9

Application for Support (Post-Mortem Application)

(In katakana)		Relationship with the beneficiary who has died	
Name			
Country of residence			
Address			
Telephone no.	(include the country code)		
Receiving account	Financial institution		
	Head/branch office		
	Account no.		
	Account holder		
Amount of application	In local currency	(currency) (* Leave this field blank)	
	In Japanese yen	yen (currency) (* Leave this field blank)	

Beneficiary who has died	Support availability notification no.				–					
	In katakana									
	Name									
	Address at the time of death									
	Date of death									

* Attach a copy of bankbook or other document that verifies your receiving account.
* The account holder must be the applicant himself/herself.
* The applicant should attach a document that authorizes him/her as an heir to the beneficiary who has died.

As specified above, I apply for support in health and medical expenses paid by the beneficiary _____ in fiscal year_____, with the submission of necessary documents.
I swear, in the event of dispute post receipt of the relevant support in health and medical expenses, not only that the Governor / Mayor of shall not be held liable, but also that I shall take complete responsibility.

Date: / /

Name of applicant:

(seal or signature)

To: Governor / Mayor of :

(Japanese Industrial Standards A4 Format)

Form No. 10

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

Date: / /

To: Governor / Mayor of :

Address after change:
Name after change:
(seal or signature)

I report the change as specified below, with the submission of a copy of the support availability notification.

Support availability notification no.		–
Change of name	*In katakana*	
	Name before change	
	In katakana	
	Name after change	
Change of address	Address before change	
	Address after change	
Change of telephone number	Telephone number before change	(include the country code)
	Telephone number after change	(include the country code)
Date of change		/ /

* Attach documents that verify the change(s) and that authenticate the beneficiary.

(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.