Attachment 1

2014 edition

Ministry of Health, Labour and Welfare, Japan
Hiroshima City

To Overseas Atomic Bomb Survivors
- Procedures for the Medical Expense Support Program for Overseas Atomic Bomb Survivors -

Overseas residents who have Atomic Bomb Survivor's Certificates or Atomic Bomb Survivor Statements of Recognition (Statements of Recognition for Situation with regard to Atomic Bombing) are entitled to receive support for medical expenses paid through insurance policies.

This support program will cover medical expenses paid during the 12 months from January to December 2014.

It should be noted that from 2014, the maximum limit to the medical expenses which can be reimbursed by the simple procedure such as with receipts has been increased to 300,000 yen per year.

Furthermore, when there is out-of-pocket medical expense exceeding the 300,000 yen limit, support for the amount exceeding the limit will be possible with papers certifying the contents of the medical care received and relevant expenses for the year filled out by the medical institution who provided treatment attached to the application.

As application for Medical Expense Support, you could follow the procedures below for application.

* If you are applying for the first time and have any questions, please feel free to make inquiries to the contact listed on page 7.

Description

1. Application forms

Please confirm whether the out-of-pocket medical expense during the 1 year from January to December 2014 is under 300,000 yen or exceeds 300,000 yen using receipts. Depending on which you fall under, the

following papers should be submitted.

(1) When the out-of-pocket medical expense is 300,000 yen or less

(i) Application Form (Form number 1 to Form number 1-3)
Please complete the necessary information in the formats provided on pages 8-10 of this notice.

* If you are applying for the first time, the List of Medical Institutions to be Visited found on page 26 must be submitted.
* Please submit the "Notification of change(s) in Confirmed Information (Change in the Medical Institutions to be Visited)" (Form number 3) on Page 23 with required information, when there is any addition or change in the information specified in the List of Medical Institutions to be Visited previously submitted.

(ii) Identity verification documents
A governmental certificate verifying identity (received within one month of issue) must be submitted.
e.g., one of the following: a family register, an abstract of a family register, an attestation by a notary public, a certificate of residence, or evidence of residency, etc.

* However, if you are a recipient of Health Management Allowance, Health Allowance, Special Medical Care Allowance, Special Allowance, or Atomic Bomb Microcephaly Allowance at the time of submitting the Application Form (Form number 1), it is not necessary to submit any one of these certificates.

(iii) Certificate verifying that you are a bomb survivor
Please submit a copy of one of the following.
- Atomic Bomb Survivor's Certificate
- Statements of Recognition for Situation with regard to Atomic Bombing (Atomic Bomb Survivor Statements of Recognition)
- Notification of the Confirmation of Eligibility

* When there is a change in name, address, or phone number, the "Notification of change in Confirmed Information (Change in Name, Address, and/or Telephone number)" (Form number 4) on

page 24 must be submitted.

(iv) Document confirming the bank account into which funds will be transferred
Please submit a photocopy of a bank book, etc.

(v) Receipt from the medical institution
Please submit receipt from the medical institution you paid during the 12 months from January to December 2014.

The receipt from the medical institution described above must specify the following four points.

1) Amount paid to the medical institution
2) Name of the payer (it should be identical to the name of applicant)
3) Name, address, and telephone number of the medical institution
4) Date of the payment to the medical institution

* Please make the amount of medical expense clear by suitable means such as by underlining. If submitted receipts include medical expenses for person(s) other than the applicant, please make payment for the applicant clear by underlining only the portion for the applicant.
* With regard to a receipt, please make sure to submit original one (copy unacceptable). (A copy may be accepted if there are special reasons.)

(vi) Application Form for Confirmation of Eligibility (Form number 5)
Only those who are applying for the first time should fill out the form on page 25 and submit it along with other papers.

(vii) List of Medical Institutions to be Visited (Form number 6)
Only those who are applying for the first time should fill out the form on page 26 and submit it along with other papers.

(2) When the out-of-pocket medical expense exceeds 300,000 yen

First, confirm the total medical expenses for the year.
When the total medical expenses are 1,500,000 yen and above (5 times

or more of the maximum limit),please submit the following papers.
When the following papers are unable to be obtained, application should be done in the previous method (described in 1. (1) of page 2), in which the receipts showing the expenses for medical care are attached. However, in this case, the maximum limit to the amount which can be reimbursed will be 300,000 yen.

(i) Application Form (Form number 2 to Form number 2-2)
Please complete the necessary information in the formats provided on pages 11-12 of this notice.

* If you are applying for the first time, please submit the List of Medical Institutions to be Visited found on page 26.
* Please submit the "Notification of change(s) in Confirmed Information (Change in the Medical Institutions to be Visited)" (Form number 3) on Page 23 with required information, when there is any addition or change in the information specified in the List of Medical Institutions to be Visited previously submitted.

(ii) Identity verification documents
A governmental certificate verifying identity (received within one month of issue) must be submitted.
e.g., One of the following: a family register, an abstract of the family register, an attestation by a notary public, a certificate of residence, or evidence of residency, etc.

* However, if you are a recipient of Health Management Allowance, Health Allowance, Special Medical Care Allowance, Special Allowance, or Atomic Bomb Microcephaly Allowance at the time of submitting the Application Form (Form number 1), it is not necessary to submit any one of these certificates.

(iii) Certificate verifying that you are a bomb survivor
Please submit a copy of one of the following.

- Atomic Bomb Survivor's Certificate
- Statements of Recognition for Situation with regard to Atomic Bombing (Atomic Bomb Survivor Statements of Recognition)
- Notification of the Confirmation of Eligibility

* When there is a change in name, address, or phone number, please submit the "Notification of Change in Confirmed Information

(Change in Name, Address, and/or Telephone number)" (Form number 4) on page 24.

(iv) Document confirming the bank account into which funds will be transferred
Please submit a photocopy of a bank book, etc.

(v) Attending Physician's Statement filled out by the medical institution (Form number 2-3 to 7)
The formats on page 13-22 must be submitted to the medical institution where medical care was provided, to have the details of the treatment contents and medical expenses paid filled out according to in-patient, out-patient, and dental.
Those who are certified as an atomic bomb disease and were provided medical care for that disease must let the medical institution know the name of the disease in which you received the certification as an atomic bomb disease, and submit Form number 2-6 on page 19 or Form number 2-7 on page 21 to have filled out, separate from other diseases.

(vi) Certificate verifying insurance benefits
When there is a benefit for the expense of medical care, such as public insurance, which should be deducted from the medical expense, please attach materials showing the amount.

(vii) A Copy of the Certificate of Atomic Bomb Disease
Those who are certified as atomic bomb disease must submit this form.

(viii) Application Form for Confirmation of Eligibility (Form number 5)
Only those who are applying for the first time should fill out the form on page 25 and submit it along with other papers.

(ix) List of Medical Institutions to be Visited (Form number 6)
Only those who are applying for the first time should fill out the form on page 26 and submit it along with other papers.

2. Coverage period of support for medical expenses

The medical expense support for 2014 is for the medical expense paid during the 1 year from January to December 2014.

3. Application deadline and mailing address

Papers should be mailed so that they arrive at the following address no later than each of the established deadlines.
Before mailing, please make sure that all of the papers necessary for application are enclosed by using the checklist provided on page 27 (when 300,000 yen or less) or page 28 (when exceeding 300,000 yen).

(1) When 300,000 yen or less
Until January 30, 2015 (Friday)

(2) When exceeding 300,000 yen
Until March 31, 2015 (Tuesday)

[Address]
Medical Expense Support Program for Overseas Atomic Bomb Survivors
Japan Public Health Association
1-29-8, Shinjuku, Shinjuku-ku, Tokyo 160-0022, Japan

4. Transfer of funds for medical expense reimbursement

(1) When 300,000 yen or less
The transfer procedures will have been implemented by March 31, 2015.

(2) When exceeding 300,000 yen
The transfer procedures will have been implemented promptly after the completion of the review.
* Please be forewarned that the review will take time.
* Please make sure to contact us if you change your bank account before that time.

5. Notification of the Confirmation of Eligibility

If you are applying for the first time, you will receive a Notification of the Confirmation of Eligibility from Hiroshima city.

The notification number of the confirmation of eligibility stated in the Notification of the Confirmation of Eligibility must be written on the application form.

This will be necessary for the application from next year, and so it should be kept in a safe place.

If you have any questions, please feel free to contact the below.

Japan Public Health Association
In Charge of Project for Overseas Atomic Bomb Survivors
Tel **+81-3-3352-4281**
Fax **+81-3-3352-4605**
E-mail **zaigai@jpha.or.jp**

Form number 1

Application Form for Medical Expense Support (When 300,000 yen or less)

Notification number of the confirmation of eligibility for Medical Expense Support				-					
Name		Date of birth (M/D/Y)				Sex: Male/Female			
Country of residence									
Address									
Telephone number	(Begin with country code)								
Fax / E-mail									
Bank account for transfer	Name of financial institution								
	Branch name (* 1)								
	Branch address (* 2)								
	Account No. (* 3)								
	Name of account holder (* 4)								
Receipt or non-receipt of any allowance at the application (*5)		Receipt / Non-receipt							
Amount of grants applied for	In local currency: (unit) (* For official use only)								
	In Japanese yen: Yen value (* For official use only)								

* 1 Please make sure that the name of the branch is filled in.
* 2 Please be sure to fill in the address of branch
* 3 Attach papers which confirm the bank account for transfer, such as a copy of a bankbook, etc.
* 4 Bank accounts must be in the name of the person possessing eligibility.
* 5 If you are a recipient of Health Management Allowance, Health Allowance, Special Medical Care Allowance, Special Allowance, or Atomic Bomb Microcephaly Allowance at this application, please check “Receipt”.

Mayor of Hiroshima City

I hereby apply for the Medical Expense Support for 2014 with the related documents attached.

Date: / / (M/D/Y)

Name of applicant: Seal (Signature)

(If you apply on behalf of the applicant, please fill in here.)

Name of proxy applicant:

Proxy applicant contact details:

* Please provide the details on which you can be reached during office hours.

Form number 1-2

Details of Grants Applied for (When 300,000 yen or less)

	Amount	Remarks (Name of hospital in case of hospitalization)
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		
Total		

Note 1: Paste receipts of expenses to Page 10 (categorize receipts by month) (Form number 1-3).
Note 2: Write amounts in the monetary unit of the country of residence.

Form number 1-3

Attached Receipts for the Month of ( )

Note 1: Receipts must have the following:
(1) Amount paid to the medical institution
(2) Name of the payer (it should be identical to the name of applicant)
(3) Name, address, and telephone number of the medical institution
(4) Date of the payment to the company

Note 2: Any receipts submitted will not be returned.

Note 3: Please photocopy this form and prepare one for each month, as necessary. Submission in other formats is acceptable as long as the months are clearly stated.

Form number 2

Application Form for Medical Expense Support (When exceeding 300,000 yen)

Notification number of the confirmation of eligibility for Medical Expense Support					-					
Name		Date of birth (M/D/Y)					Sex: Male/Female			
Country of residence										
Address										
Telephone number	(Start from country code)									
Fax / E-mail										
Bank account for transfer	Name of financial institution									
	Branch name (* 1)									
	Branch address (* 2)									
	Account No. (* 3)									
	Name of account holder (* 4)									
Certified or not certified as an atomic bomb disease at the application (*5)										
Receipt or non-receipt of any allowance at the application (*6)										
Amount of grants applied for	In local currency: (unit) (* For official use only)									
	In Japanese yen: Yen value (* For official use only)									

Certified or not certified as an atomic bomb disease at the application (*5)	Certified / Not certified	
Receipt or non-receipt of any allowance at the application (*6)	Receipt / Non-receipt	

* 1 Please make sure that the name of the branch is filled in.
* 2 Please be sure to fill in the address of branch.
* 3 Attach papers which confirm the bank account for transfer, such as a copy of a bankbook, etc.
* 4 Bank accounts must be in the name of the person possessing eligibility.
* 5 If you are certified as an atomic bomb disease, please check “Certified.”
* 6 If you are a recipient of Health Management Allowance, Health Allowance, Special Medical Care Allowance, Special Allowance, or Atomic Bomb Microcephaly Allowance at this application, please check “Receipt”.

Mayor of Hiroshima City

I hereby apply for the Medical Expense Support for 2014 with the related documents attached.
Date: / / (M/D/Y)
Name of applicant: Seal (Signature)

(If you apply on behalf of the applicant, please fill in here.)
Name of proxy applicant:
Proxy applicant contact details:
* Please provide the details on which you can be reached during office hours.

Form number 2-2

Details of Grants Applied for (When exceeding 300,000 yen)

Grant year	Medical expense (i)	Amount of insurance benefits (ii)	Amount of out-of pocket (iii) ((i) - (ii))	Remarks
2014				

(Note1) For the “Medical expense” column, when Form number 2-3 to 2-7 are submitted to the medical institution to have filled out the details of the treatment contents and medical expenses paid, the total amount of medical expense shall be stated based on this.

(Note 2) For the “Amount of insurance benefits” column, when there are insurance benefits for the relevant medical care, certifying documents shall be issued by the insurance company and the certified benefit amount shall be stated.

(Note 3) For the “Amount of out-of pocket” column, state the amount after the amount of insurance benefits is deducted from medical expenses.

(Note 4) State amounts in the monetary unit of the 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. Prepare for the 1 year from January to December 2014.
* 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 2014)

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. Prepare for the 1 year from January to December 2014.
* 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 2014)

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. Prepare for the 1 year from January to December 2014.
* When statements do not fit on this form, please use multiple forms or use arbitrary forms for descriptions.
(4) Under "*14. Others", enter whatever information that is not provided in 1 through 13.

Attending Dentist's Statement (for year 2014)

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	
Right	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	Left
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
	#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. Prepare for the 1 year from January to December 2014.
* 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.
* When statements do not fit on this form, please use multiple forms or use arbitrary forms for descriptions.
(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 7.

Attending Physician's Statement (for year 2014)

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. Prepare for the 1 year from January to December 2014.
* 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.
* When statements do not fit on this form, please use multiple forms or use arbitrary forms for descriptions.
(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 7.

Attending Physician's Statement (for year 2014)

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 number 3

Notification of Change(s) in Confirmed Information (Change in Medical Institutions to be Visited)

Date: / / (M/D/Y)

Mayor of Hiroshima City

Country of residence
Address:
In Katakana
Name:

Telephone Number (Start from country code)

Name of medical institutions	Address of medical institutions	Telephone Number (Start from country code)

Form Number 4

Notification of Change(s) in Confirmed Information (Change in Name, Address and/or Telephone Number)

Date: / / (M/D/Y)

Mayor of Hiroshima City

(New) Address:

(New) Name: Seal (Signature)

I hereby notify the change(s) in the Name, address and/or telephone number as follows with attached a copy of one of the following, Notification of the Confirmation of Eligibility, Atomic Bomb Survivor's Certificates, or Statements of Recognition for Situation with regard to Atomic Bombing (Atomic Bomb Survivor Statements of Recognition).

Notification number of the confirmation of eligibility for Medical Expense Support				-					
Change in name	*In Katakana*								
	Former name								
	In Katakana								
	New name								
Change in address	Former address								
	New address								
Change in telephone number	Former number	(Start from country code)							
	New number	(Start from country code)							
Date of the change(s)		(M/D/Y)							

* Documents confirming the change(s) specified above and the identity of the individual in question should also be attached.

Form number 5

* You must submit this form if you are applying for the first time. Those who are already registered are not required to submit this form.

Application Form for Confirmation of Eligibility

In Katakana		Date of birth		Sex:
Name		(M/D/Y)		Male/Female
Country of residence				
In Katakana				
Address				
Telephone number	(Start from country code)			
Fax / E-mail				
Type	( ) Atomic Bomb Survivor's Certificate ( ) Statements of Recognition for Situation with regard to Atomic Bombing (or Atomic Bomb Survivor Statements of Recognition) *Place a circle in either one.			

Supporting prefecture/city									
Atomic Bomb Survivor's Certificate No.								-	
Number of the Statements of Recognition for Situation with regard to Atomic Bombing (or the Atomic Bomb Survivor Statements of Recognition)									

Mayor of Hiroshima City

I hereby submit the respective documents for the confirmation of eligibility for Medical Expense Support.

Date: / / (M/D/Y)

Name of applicant:
Seal (Signature)

(If you apply on behalf of the applicant, please fill in here.)

Name of proxy applicant:
Proxy applicant contact details:

* Please provide the details on which you can be reached during office hours.

Form number 6
* You must submit this form if you are applying for the first time. Those who are already registered are not required to submit this form.

List of Medical Institutions to be Visited

(Please write the name of medical institution(s) you visit regularly or your regular medical institution below.)

Date: / / (M/D/Y)

Mayor of Hiroshima City

Country of residence
Address:
In Katakana
Name:
Telephone Number (Start from country code)

Name of medical institutions	Address of medical institutions	Telephone Number (Start from country code)

Checklist for Documents to be Submitted (When 300,000 yen or less)

* Before submitting documents, please make sure that all of necessary documents are enclosed by using this checklist.

Enclosed or not	Documents to be submitted
☐	Application Form (When 300,000 yen or less) (page 8)
☐	Details of Grants Applied for (When 300,000 yen or less) (page 9)
☐	A governmental certificate verifying identity (received within one month of issue) (a family register, an abstract of the family register, an attestation by a notary public, a certificate of residence, or evidence of residency, etc.) * However, if you are a recipient of Health Management Allowance, Health Allowance, Special Medical Care Allowance, Special Allowance, or Atomic Bomb Microcephaly Allowance at the time of submitting the Application Form, it is not necessary to submit any one of these certificates.
☐	A copy of one of the following, Notification of the Confirmation of Eligibility, Atomic Bomb Survivor's Certificate, or Statements of Recognition for Situation with regard to Atomic Bombing (Atomic Bomb Survivor Statements of Recognition)
☐	Document confirming the bank account into which funds will be transferred, such as a photocopy of a bank book, etc.
☐	Receipts from the medical institution (attached to the form "Attached Receipts for the Month of" of page 10) *1: Please make the amount of medical expense clear by suitable means such as by underlining. *2: If submitted receipts include medical expenses for person(s) other than the applicant, please make payment for the applicant clear by underlining only the portion for the applicant.
☐	Notification of Change(s) in Confirmed Information (only when you have changed your medical institutions to be visited (page 23), or your address, etc. (page 24))

* Those who are applying for the first time must submit the following along with other papers.

☐	Application Form for Confirmation of Eligibility (page 25)
☐	List of Medical Institutions to be Visited (page 26)

Checklist for Documents to be Submitted (When exceeding 300,000 yen)

* Before submitting documents, please make sure that all of necessary documents are enclosed by using this checklist.

Enclosed or not	Documents to be submitted
☐	Application Form (When exceeding 300,000 yen) (page 11)
☐	Details of Grants Applied for (When exceeding 300,000 yen) (page 12)
☐	A governmental certificate verifying identity (received within one month of issue) (a family register, an abstract of the family register, an attestation by a notary public, a certificate of residence, or evidence of residency, etc.) * However, if you are a recipient of Health Management Allowance, Health Allowance, Special Medical Care Allowance, Special Allowance, or Atomic Bomb Microcephaly Allowance at the time of submitting the Application Form, it is not necessary to submit any one of these certificates.
☐	A copy of one of the following, Notification of the Confirmation of Eligibility, Atomic Bomb Survivor's Certificate, or Statements of Recognition for Situation with regard to Atomic Bombing (Atomic Bomb Survivor Statements of Recognition)
☐	Document confirming the bank account into which funds will be transferred, such as a photocopy of a bank book, etc.
☐	Attending Physician's Statement filled out by the medical institution (page 13-22)
☐	Certificate verifying insurance benefits *If full amount of insurance benefits was described in Attending Physician's Statement, it is not necessary to submit these certificates.
☐	Notification of Change(s) in Confirmed Information (only when you have changed your medical institutions to be visited (page 23), or your address, etc. (page 24))
☐	Copy of the certificate of Atomic Bomb Disease (Only those who are certified as atomic bomb disease)

* Those who are applying for the first time must submit the following along with other papers.

☐	Application Form for Confirmation of Eligibility (page 25)
☐	List of Medical Institutions to be Visited (page 26)