Form A（様式 A）

Attending Physician's Statement

診 療 内 容 明 細 書

1. Name of Patient（Last,First） Age（Date of Birth） Sex（Male・Female）
患者名＿＿＿＿＿＿＿＿＿＿＿＿ 年齢（生年月日）＿＿＿＿＿＿＿＿ 性別（男・女）＿＿＿＿＿＿

2. Name of Illness or Injury preferably with Number of International Classification of diseases for the use National Health Insurance (See the Table of International Classification of Diseases)
傷病名及び国民健康保険用国際疾病分類番号（別紙 国際疾病分類表参照）

3. Date of First Diagnosis： D ／ M ／ Y ＿＿／＿＿／＿＿
初診日 日 ／ 月 ／ 年 ＿＿／＿＿／＿＿

4. Duration of Treatment：＿＿＿＿ days
診療日数 ＿＿＿＿ 日

5. Type of Treatment
治療の分類
☐ Hospitalization： From ＿＿／＿＿／＿＿,to ＿＿／＿＿／＿＿（ days)
入院 自 ＿＿／＿＿／＿＿至 ＿＿／＿＿／＿＿（ 日間)
☐ Outpatient or Home Visit： ＿＿／＿＿／＿＿ ＿＿／＿＿／＿＿
入院外 ＿＿／＿＿／＿＿ ＿＿／＿＿／＿＿

6. Nature and Condition of Illness or Injury（in brief)
症状の概要

7. Prescription, Operation and Any other treatments(in brief)
処方、手術その他の処置の概要

8. Was the treatment required as a result of an accidental injury? Yes ☐ No ☐
治療は事故の損害によるものですか。 はい いいえ

9. Itemized Amounts paid to Hospital and/ or Attending Physician : Form B
治療実費（様式 B に記入）

10. Name and Address of Attending Physician
担当医の名前及び住所
Name 名前 ： Last 姓 ＿＿＿＿ First 名 ＿＿＿＿ Title 称号 ＿＿＿＿
Address 住所 ： Home 自宅 ＿＿＿＿ Phone 電話 ＿＿＿＿
Office 病院又は診療所 ＿＿＿＿ Phone 電話 ＿＿＿＿
Date 日付 ： ＿＿＿＿ Signature 署名 ＿＿＿＿
Attending Physician 担当医

Reference Number of your Medical Record（if applicable)
診療録の番号 ＿＿＿＿

※「6.症状の概要」及び「7.処方、手術その他の処置の概要」について、詳細資料がある場合は、日本語訳と供して添付してください。

Kamakura — 国民健康保険異動届出書 — National Health Insurance Application

Deadline: Must be submitted within 14 days of the qualifying event (losing employer insurance, moving in, birth, etc.) | Cost: Free | Penalty: Late enrollment means you still owe premiums from the eligibility date, and medical costs in

WHAT TO BRING

>> Enrolling after leaving employer insurance

* Certificate of Health Insurance Loss (from former employer)	健康保険資格喪失証明書
* Residence Card	在留カード
* My Number Card (or My Number notification)	マイナンバーカード
Bank passbook & registered seal (for auto-debit setup)	通帳・届出印

>> Enrolling after moving to a new ward

* Residence Card	在留カード
* My Number Card	マイナンバーカード
Moving-Out Certificate (from previous ward) (If also doing residence registration)	転出証明書

>> Leaving NHI (got employer insurance)

* New health insurance card (from employer)	新しい健康保険証
* NHI qualification confirmation document	国民健康保険資格確認書
* My Number Card	マイナンバーカード

COMMON MISTAKES

X Not enrolling within 14 days
-> You owe premiums retroactively from the eligibility date, but medical expenses during the gap are not covered.

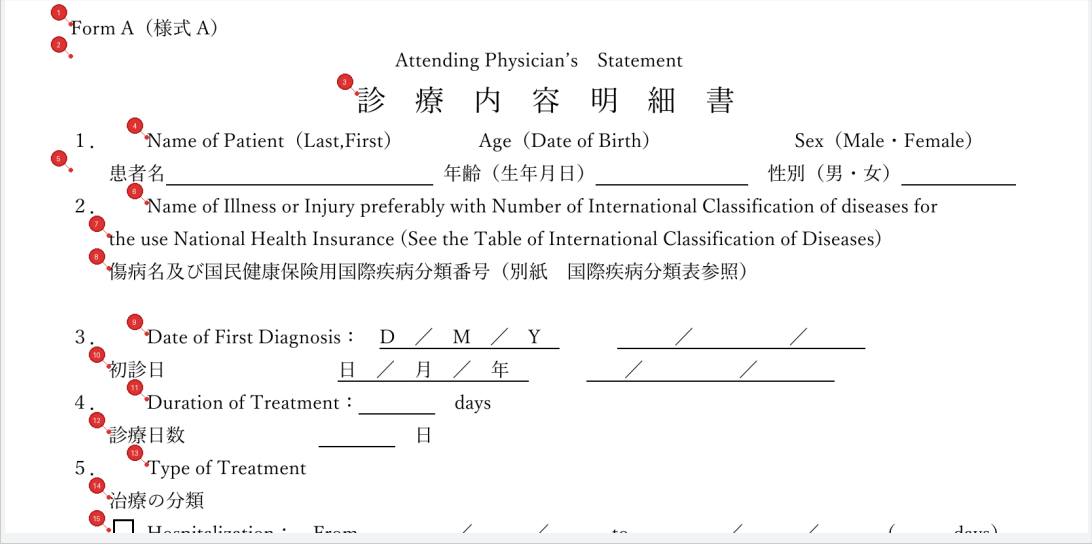
X Forgetting to disenroll from NHI after getting employer insurance
-> You will be double-billed for premiums. NHI does not automatically cancel.

X Not bringing the Certificate of Health Insurance Loss
-> The ward office cannot process your enrollment. Ask your former employer to issue this document.

AFTER YOU SUBMIT

1. You receive a qualification confirmation document (資格確認書) — keep this as proof of insurance
2. Monthly premium notices arrive by mail. Pay at convenience stores, banks, or set up auto-debit
3. Dependents can be enrolled on the same form — list all household members
4. Premiums are calculated based on your previous year's income

セクション 1 — Section 1



Form A（様式 A）

Attending Physician's Statement

診 療 内 容 明 細 書

1. Name of Patient（Last,First） Age（Date of Birth） Sex（Male・Female）
患者名＿＿＿＿＿＿＿＿＿＿＿＿ 年齢（生年月日）＿＿＿＿＿＿ 性別（男・女）＿＿＿＿＿＿

2. Name of Illness or Injury preferably with Number of International Classification of diseases for the use National Health Insurance (See the Table of International Classification of Diseases)
傷病名及び国民健康保険用国際疾病分類番号（別紙 国際疾病分類表参照）

3. Date of First Diagnosis： D ／ M ／ Y ＿＿＿＿／＿＿＿＿／＿＿＿＿
初診日 日 ／ 月 ／ 年 ＿＿＿＿／＿＿＿＿／＿＿＿＿

4. Duration of Treatment：＿＿＿＿ days
診療日数 ＿＿＿＿ 日

5. Type of Treatment
治療の分類

☐ Hospitalization： From ／ ／ to ／ ／ (days)

1 Form A（様式A） [Form A（様式A）]

2 Attending Physician's Statement [Attending Physician's Statement]

3 診 療 内 容 明 細 書 [診療内容明細書]

4 Name of Patient（Last,First） Age（Date of Birth） Sex（Male・Female）
[Name of Patient（Last,First） Age（Date of Birth） Sex（Male・Female）]

5 患者名 年齢（生年月日） 性別（男・女）
Date of birth / Male・Female / Gender
Format: 年(year) 月(month) 日(day). Use Japanese calendar (令和/平成) or Western year.
Circle or check the appropriate gender

6 Name of Illness or Injury preferably with Number of International Classification of diseases for
[Name of Illness or Injury preferably with Number of International Classification of diseases for]

7 the use National Health Insurance (See the Table of International Classification of Diseases)
[the use National Health Insurance (See the Table of International Classification of Diseases)]

8 傷病名及び国民健康保険用国際疾病分類番号（別紙 国際疾病分類表参照） National Health Insurance
Japan's public health insurance for self-employed, unemployed, and those not covered by employer insurance. Enrollment is mandatory.

9 Date of First Diagnosis： D / M / Y / / [Date of First Diagnosis： D / M / Y / /]

10 初診日 日 / 月 / 年 / / [初診日 日 / 月 / 年 / /]

11 Duration of Treatment： days [Duration of Treatment： days]

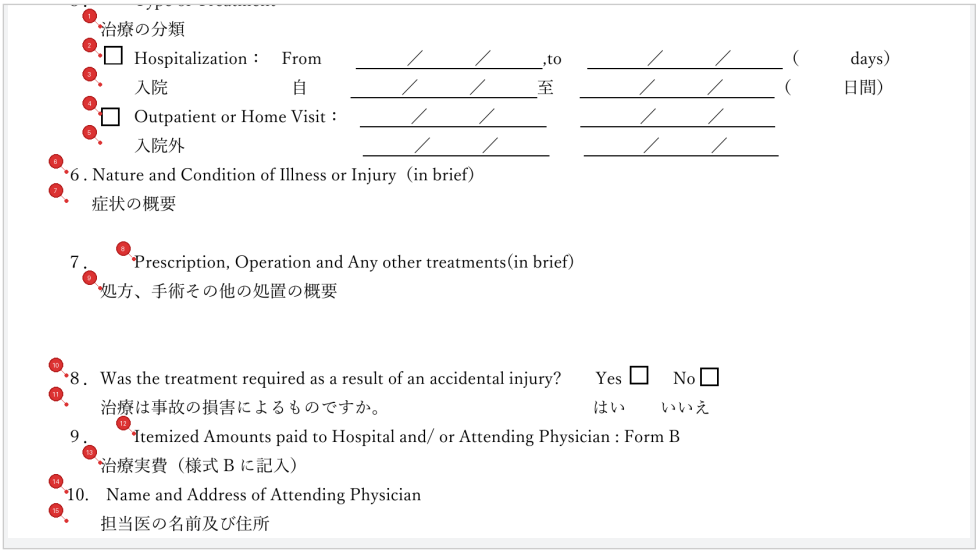
12 診療日数 日 [診療日数 日]

13 Type of Treatment [Type of Treatment]

14 治療の分類 [治療の分類]

15 Hospitalization： From / / ,to / / (days)
[Hospitalization： From / / ,to / / (days)]

セクション 2 — Section 2 (Part 1/2)



1 **治療の分類** [治療の分類]

2 Hospitalization： From / / ,to / / (days)
[Hospitalization： From / / ,to / / (days)]

3 入院 自 / / 至 / / (日間)
[入院 自 / / 至 / / (日間)]

4 Outpatient or Home Visit： / / / / [Outpatient or Home Visit： / / / /]

5 入院外 / / / / [入院外 / / / /]

6 6 . Nature and Condition of Illness or Injury (in brief) [6 . Nature and Condition of Illness or Injury (in brief)]

7 **症状の概要** [症状の概要]

8 Prescription, Operation and Any other treatments(in brief) [Prescription, Operation and Any other treatments(in brief)]

9 **処方、手術その他の処置の概要** Other
Use this section for any additional information not covered in other fields

10 8 . Was the treatment required as a result of an accidental injury? Yes No
[8 . Was the treatment required as a result of an accidental injury? Yes No]

11 **治療は事故の損害によるものですか。** **はい** **いいえ** No / Yes
Select this option to indicate 'no' or negative response to the question Check this box or circle this option to indicate 'yes' or agreement

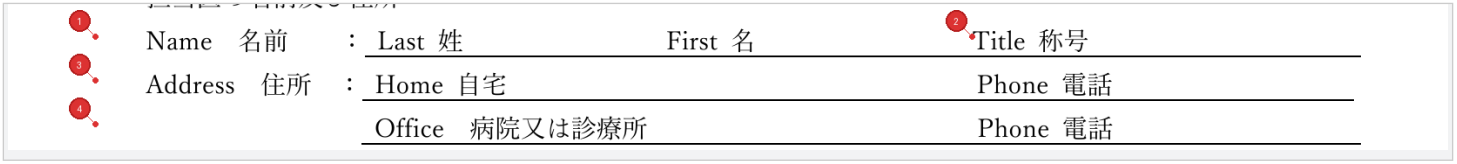
12 Itemized Amounts paid to Hospital and/ or Attending Physician : Form B
[Itemized Amounts paid to Hospital and/ or Attending Physician : Form B]

13 **治療実費 (様式Bに記入)** [治療実費 (様式Bに記入)]

14 10. Name and Address of Attending Physician [10. Name and Address of Attending Physician]

15 **担当医の名前及び住所** Address
Write in kanji if possible. Ward office staff can help you look up the correct kanji for your address.

セクション 2 — Section 2 (Part 2/2)



1 **Name 名前 ： Last 姓** **First 名** [Name 名前 ： Last 姓 First 名]

2 **Title 称号** [Title 称号]

3 **Address 住所 ： Home 自宅** **Phone 電話** Address / Home address

Write in kanji if possible. Ward office staff can help you look up the correct kanji for your address. Enter your residential address where you actually live

4 **Office 病院又は診療所** **Phone 電話** [Office 病院又は診療所 Phone 電話]

セクション 3 — Section 3

Office 病院又は診療所 Phone 電話

Date 日付 ： Signature 署名

Attending Physician 担当医

Reference Number of your Medical Record（if applicable）

診療録の番号

※「6.症状の概要」及び「7.処方、手術その他の処置の概要」について、詳細資料がある場合は、日本語訳と供して添付してください。

1 Address 住所 ： Home 自宅 Phone 電話 Address / Home address
Write in kanji if possible. Ward office staff can help you look up the correct kanji for your address. Enter your residential address where you actually live

2 Office 病院又は診療所 Phone 電話 [Office 病院又は診療所 Phone 電話]

3 Date 日付 ： Signature 署名 Signature
Sign your name. Foreigners can use a written signature instead of a seal (inkan).

4 Attending Physician 担当医 [Attending Physician 担当医]

5 Reference Number of your Medical Record (if applicable) [Reference Number of your Medical Record (if applicable)]

6 診療録の番号 [診療録の番号]

7 ※「6.症状の概要」及び「7.処方、手術その他の処置の概要」について、詳細資料がある場合は、日本語訳 Other
Use this section for any additional information not covered in other fields

8 と供して添付してください。 [と供して添付してください。]

Form p.1

COUNTER PHRASES

Point and show these to ward office staff

FINDING THE COUNTER

すみません、国民健康保険の窓口はどこですか？
Sumimasen, kokumin kenkō hoken no madoguchi wa doko desu ka?
Excuse me, where is the National Health Insurance counter?

ENROLLING

国民健康保険に加入したいのですが
Kokumin kenkō hoken ni kanyū shitai no desu ga
I would like to enroll in National Health Insurance

CANCELLING

国民健康保険をやめたいのですが
Kokumin kenkō hoken wo yametai no desu ga
I would like to cancel my National Health Insurance

SHOWING PROOF

資格喪失証明書を持っています
Shikaku sōshitsu shōmeisho wo motteimasu
I have my Certificate of Health Insurance Loss

ASKING ABOUT PREMIUMS

保険料はいくらですか
Hokenryō wa ikura desu ka?
How much is the insurance premium?

LEFT PREVIOUS JOB

会社を辞めたので、国保に切り替えたいです
Kaisha wo yameta node, kokuho ni kirikae tai desu
I left my company and want to switch to National Health Insurance