

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 incurred during the gap are not covered.

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

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 (Format A)

This indicates the form type - no action needed as it's pre-printed on the form.

② Attending Physician's Statement Attending Physician's Statement

This is the title section - no action needed as it's pre-printed header text.

③ 診療内容明細書 Medical Treatment Details Statement

N/A if it's just instructions/layout text

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)

Write the patient's full name (family name first, then given name), age in years, birth date, and circle either 'Male' or 'Female' for sex.

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

Enter the specific medical condition or injury name, preferably including the ICD (International Classification of Diseases) code if known.

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)

This is explanatory text about using ICD codes for National Health Insurance - refer to the separate ICD classification table when filling out field 6.

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 / /

Write the date when the condition was first diagnosed in Day/Month/Year format using numbers (e.g., 15/03/2024).

⑩ 初診日 日 / 月 / 年 / /

Initial consultation date day / month / year / /

N/A - this appears to be medical form text that was mistakenly included, as residence registration forms don't typically require medical consultation dates



セクション 1 — Section 1 (continued)

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)

11 Duration of Treatment : days Duration of Treatment: days

Enter the number of days for medical treatment if this section applies to your situation (often related to hospitalization or extended medical care).

12 診療日数 日 Number of days

Enter the total number of days for the period being reported

13 Type of Treatment Type of Treatment

Describe the type of medical treatment being provided (e.g., medication, surgery, physical therapy, etc.).

14 治療の分類 Classification of Treatment

This is the Japanese translation of 'Type of Treatment' above - the content should match what you write in field 13.

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

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

Fill in dates if you were hospitalized during the period relevant to your residence registration - format is typically year/month/day in Japanese forms.

セクション 2 — Section 2 (Part 1/2)

<p>1. 治療の分類</p> <p><input type="checkbox"/> Hospitalization : From / / , to / / (days) 入院 自 / / 至 / / (日間)</p> <p><input type="checkbox"/> Outpatient or Home Visit : / / / / 入院外 / / / /</p> <p>6. Nature and Condition of Illness or Injury (in brief) 症状の概要</p> <p>7. Prescription, Operation and Any other treatments(in brief) 処方、手術その他の処置の概要</p> <p>8. Was the treatment required as a result of an accidental injury? Yes <input type="checkbox"/> No <input type="checkbox"/> 治療は事故の損害によるものですか。 はい いいえ</p> <p>9. Itemized Amounts paid to Hospital and/ or Attending Physician : Form B 治療実費 (様式 B に記入)</p> <p>10. Name and Address of Attending Physician 担当医の名前及び住所</p>

1 治療の分類 Classification of Treatment

Check either 'Hospitalization' or 'Outpatient or Home Visit' to indicate the type of treatment received. Fill in dates and duration if hospitalized.

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

Hospitalization: From ____/____/, to ____/____/____ (____ days)

Fill in dates if you were hospitalized during the period relevant to your residence registration - format is typically year/month/day in Japanese forms.

3 入院 自 / / 至 / / (日間) days

Usually follows a number to indicate duration in days

4 Outpatient or Home Visit : / / / / / / / / / / /

This appears to be pre-printed English text for date fields, likely related to medical visits - leave blank unless specifically requested by your municipality.

5 入院外 / / / / / / / / / / / / /

Leave blank unless you're being discharged from a hospital - this section is for recording hospitalization-related moves

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

Provide a brief description of your medical condition, illness, or injury in simple terms. Keep it concise but clear enough for administrative understanding.

7 症状の概要 Summary of symptoms

N/A if it's just instructions/layout text

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

Describe any prescriptions, surgical procedures, or other medical treatments you received in brief. Include major medications or procedures but don't need extensive detail.

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

Check 'Yes' (はい) if your treatment was due to an accident or injury, or 'No' (いいえ) if it was for illness or routine medical care. This affects insurance coverage.



セクション 2 — Section 2 (Part 1/2) (continued)

<p>① 治療の分類</p> <p>② <input type="checkbox"/> Hospitalization : From <u> / / </u>, to <u> / / </u> (days) ③ 入院 自 <u> / / </u> 至 <u> / / </u> (日間)</p> <p>④ <input type="checkbox"/> Outpatient or Home Visit : <u> / / </u> <u> / / </u> ⑤ 入院外 <u> / / </u> <u> / / </u></p> <p>⑥ 6. Nature and Condition of Illness or Injury (in brief) ⑦ 症状の概要</p> <p>⑧ 7. Prescription, Operation and Any other treatments(in brief) ⑨ 处方、手術その他の処置の概要</p> <p>⑩ 8. Was the treatment required as a result of an accidental injury? Yes <input type="checkbox"/> No <input type="checkbox"/> ⑪ 治療は事故の損害によるものですか。 はい いいえ</p> <p>⑫ 9. Itemized Amounts paid to Hospital and/ or Attending Physician : Form B ⑬ 治療実費 (様式 B に記入)</p> <p>⑭ 10. Name and Address of Attending Physician ⑮ 担当医の名前及び住所</p>

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

This refers to a separate detailed itemized bill form (Form B) that lists all medical expenses. You'll need to attach or reference that form here.

13 治療実費 (様式Bに記入) Fill in

Write the total amount of medical expenses as detailed in Form B. This should match the itemized amounts from your hospital bills and physician fees.

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

Write the full name and complete address of the doctor or hospital that provided your treatment. Include postal code and phone number if space allows.

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 : <u>Last 姓</u>	First 名	2	Title 称号
3	Address 住所 : <u>Home 自宅</u>	Phone 電話		
4	<u>Office 病院又は診療所</u>	Phone 電話		

1 Name 名前 : Last 姓 First 名 Name - Last Name, First Name

Write your family name in the "Last 姓" field and given name in the "First 名" field using the same script (katakana/kanji/romaji) as your residence card.

2 Title 称号 Title/Honorific Title

Leave blank unless you have a specific professional or noble title (e.g., Dr., Professor, etc.)

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: Hospital or clinic

Phone: Telephone

Enter the name and phone number of the hospital or medical facility where you were born (for birth registration) or received treatment (if medical-related registration).



セクション 3 — Section 3

       	<p>Office 病院又は診療所</p> <p>Date 日付 : _____</p> <p>Signature 署名 _____</p> <p>Attending Physician 担当医</p> <p>Reference Number of your Medical Record (if applicable)</p> <p>診療録の番号 _____</p> <p>※ 「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。</p>	<p>Phone 電話</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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- 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: Hospital or clinic** **Phone: Telephone**
 Enter the name and phone number of the hospital or medical facility where you were born (for birth registration) or received treatment (if medical-related registration).
- 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** **Staff in charge**
 Staff use only - do not fill in
- 5 Reference Number of your Medical Record (if applicable)** **Reference Number of your Medical Record (if applicable)**
 If the hospital assigned you a patient ID number or medical record number, write it here; leave blank if you don't have one or it's not applicable.
- 6 診療録の番号 Number**
 Enter the relevant identification number (My Number, insurance number, etc.) as specified in the form context
- 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。 Please / Please / Please**
 This is typically part of an instruction - look for the preceding text to understand what action is requested



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, kokuhō ni kirikae tai desu

I left my company and want to switch to National Health Insurance