WORKMEN'S ACCIDENT COMPENSATION INSURANCE

Procedures for Application for Medical (Compensation) Benefit

In case of medical treatment for injury or disease caused by the industrial accident or commuting accident

Ministry of Labour
Prefectural Labour Standards Office
Labour Standards Inspection Office

When a worker has been injured or contracted a disease due to an employment-related cause or on commuting and needs medical treatment, the medical compensation benefit (in the case of industrial accident) or the medical benefit (in the case of commuting accident) is granted. (These two benefits are referred to as medical (compensation) benefits.)

Medical (compensation) benefits consist of the "medical treatment benefit" and the "payment of medical treatment expenses".

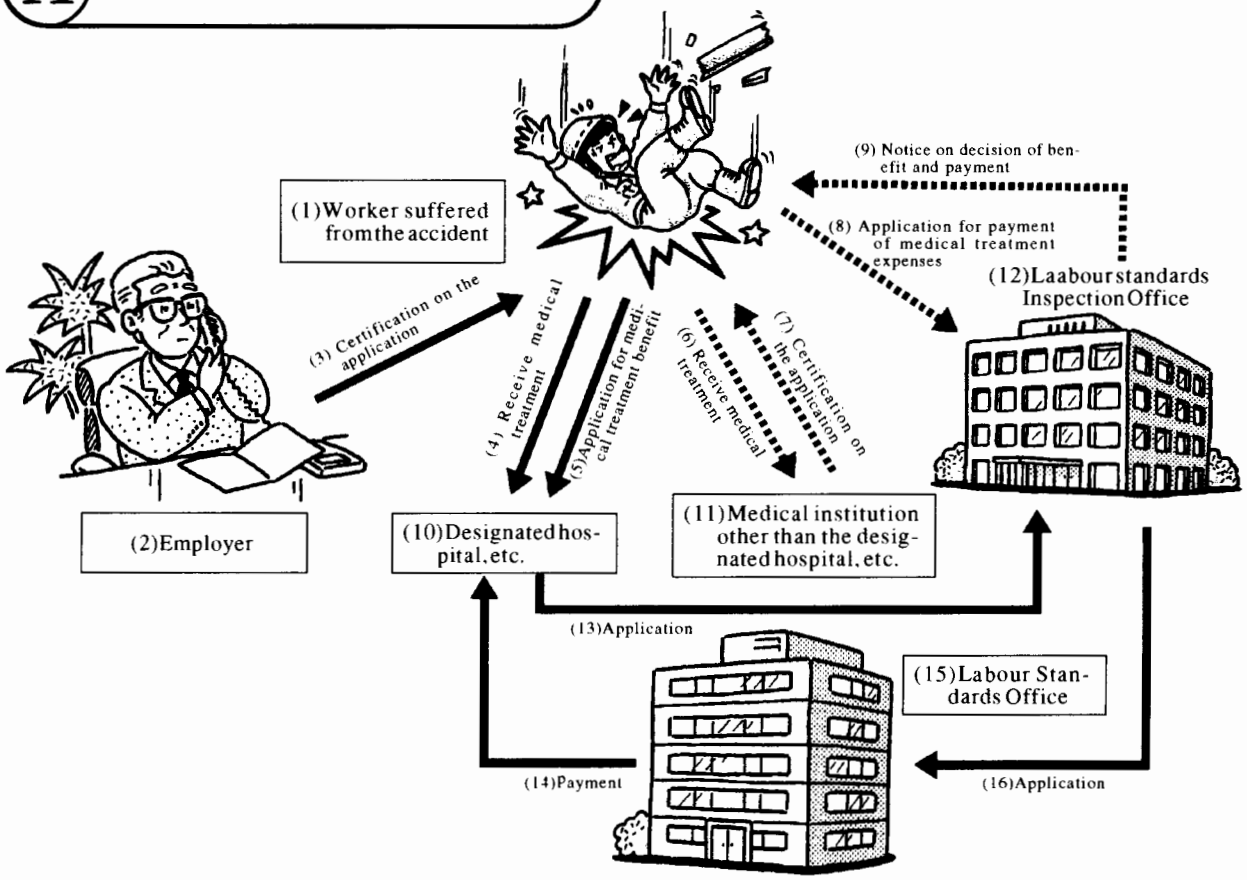
Content of Benefits

- The "medical treatment benefit" is a scheme to grant the medical treatment in kind at the Workmen's Insurance hospitals, designated hospitals, clinics and pharmacy (to be referred to as the "designated hospital, etc. ").
- The "payment of medical treatment expenses" is a scheme to grant the payment of expenses spent for the medical treatment which a worker received at a hospital, clinic or pharmacy other than the designated hospital, etc. for the reason that there is no designated hospital, etc. in his/her neighburhood.
- The range and period of medical treatment as the benefit is the same for the two schemes.
  The medical (compensation) benefit includes expenses which are usually required for medical treatment, such as medical care, nursing, transportation, etc. and is granted until the injury or disease has healed or cured.

What is "Has Healed or Cured"?

The medical (compensation) benefit is granted until the injury has healed or the disease has cured. However, the "has healed or cured" means the fact that the symptoms of the injury or disease have settled and no further effects can be expected from continuation of the generally accepted medical treatment. This is referred to as the "fixation of symptoms". Therefore, the "heal or cure" does not necessarily mean the recovery to the original physical conditions.

A Procedures for Application

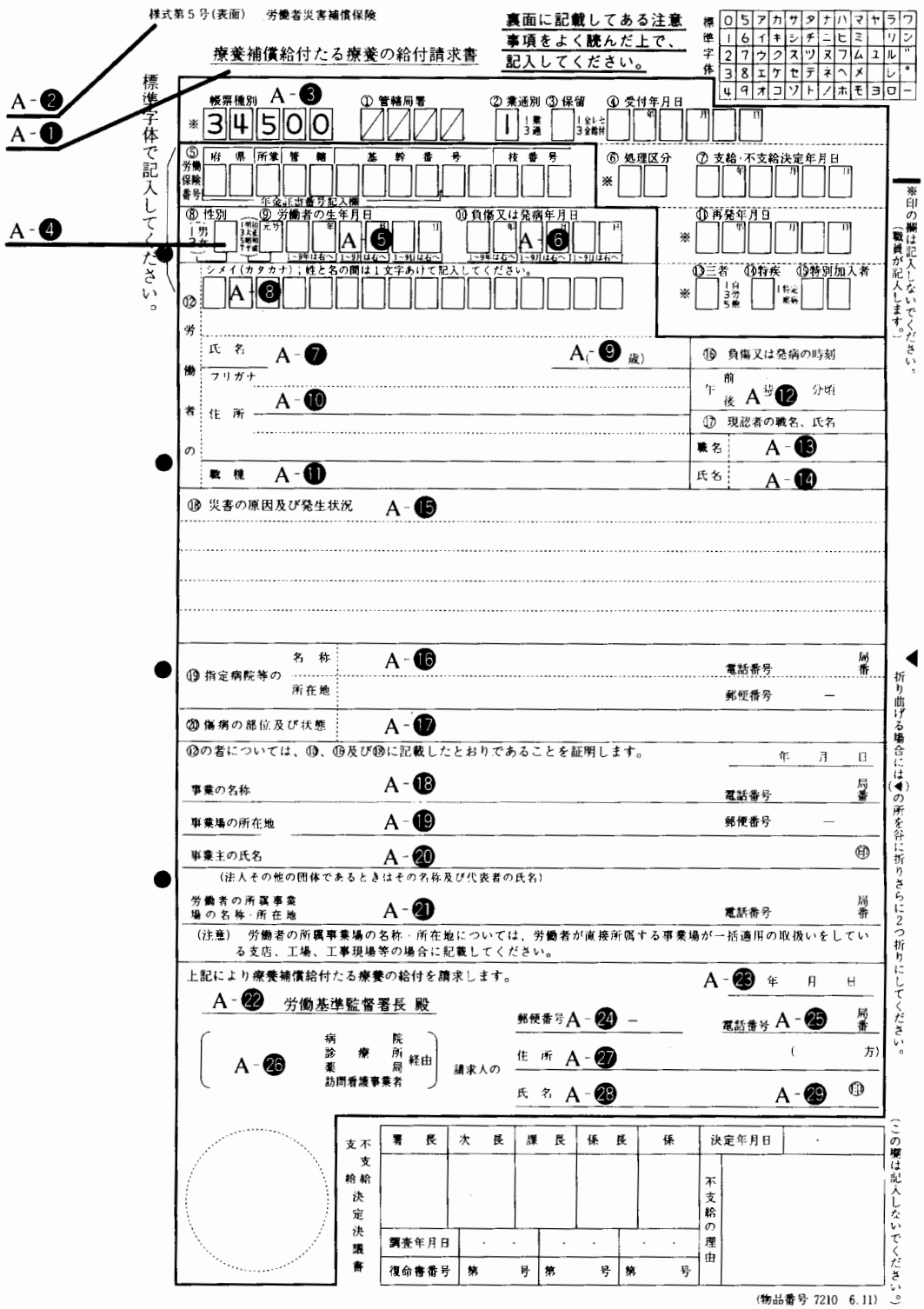


- To make the application for medical treatment benefit Please submit the Application for Benefit of Medical Treatment as a Medical Compensation Benefit (Form No.5) or the Application for Benefit of Medical Treatment as a Medical Benefit (Form NO.16-3) to the Director of Labour Standards Inspection Office having jurisdiction over the area through the designated hospital, etc. at which the worker is receiving the medical treatment.
- To make the application for payment of medical treatment expenses
  Please submit the Application for Payment of Medical Treatment Expenses as a Medical Compensation Benefit (Form No.7) or the Application for Payment of Medical Treatment expenses as a Medical Benefit (Form No,16-5) to the Director of Labour standards Inspection Office having jurisdiction over the area.
- To change the designated hospital, etc.
  When the worker who has been receiving medical treatment benefit at the designated hospital, etc. wishes to change the designated hospital, etc. to other designated hospital, etc. for the reason of returning to his/her home town, or other reasons, please submit the "Notice of (Change of) Designated Hospital, etc. at which the Benefit of Medical Treatment as a Medical Compensation Benefit is to be Received"
  (Form No.6) or the "Notice of (Change of) Designated Hospital, etc. at Which the Benefit of Medical Treatment as a Medical Benefit is to be Received" (Form NO.16-4) to the Director of Labour Standards Inspection Office having jurisdiction over the area through the designated hospital, etc. to which he/she has changed for the medical treatment.

Time Limitation concerning the Claim

There is no problem of the time limitation for the medical treatment benefit as it is granted in kind. However, as the right of claim for payment of medical treatment expenses disappears by limit of action when two years have passed from the date on which the payment of expenses has been confirmed, you are advised to pay special attention to this.

Example of How to Fill in the Application


様式第５号(表面)　労働者災害補償保険

療養補償給付たる療養の給付請求書

真面に記載してある注意事項をよく読んだ上で、記入してください。

標準字体

0	5	ア	カ	サ	タ	ナ	ハ	マ	ヤ	ラ	ワ
1	6	イ	キ	シ	チ	ニ	ヒ	ミ		リ	ン
2	7	ウ	ク	ス	ツ	ヌ	フ	ム	ユ	ル	"
3	8	エ	ケ	セ	テ	ネ	ヘ	メ		レ	°
4	9	オ	コ	ソ	ト	ノ	ホ	モ	ヨ	ロ	−

標準字体で記入してください。

A-1 A-2 A-3 A-4

帳票種別 ※ 34500

① 管轄局署　② 業通別 1 ③ 保留　④ 受付年月日

⑤ 労働保険番号　府県 所掌 管轄 基幹番号 枝番号　年金証書番号記入欄

⑥ 処理区分 ※　⑦ 支給・不支給決定年月日

⑧ 性別 1 男 2 女　⑨ 労働者の生年月日 A-5　⑩ 負傷又は発病年月日 A-6　⑪ 再発年月日 ※

⑫ 労働者の　シメイ(カタカナ)；姓と名の間は１文字あけて記入してください。 A-8

⑬ 三者 ※　⑭ 特疾　⑮ 特別加入者

※印の欄は記入しないでください。〔職員が記入します。〕

氏名 A-7　A-9 歳

フリガナ

住所 A-10

職種 A-11

⑯ 負傷又は発病の時刻　午前 午後 A-12 時 分頃

⑰ 現認者の職名、氏名　職名 A-13　氏名 A-14

⑱ 災害の原因及び発生状況 A-15

⑲ 指定病院等の　名称 A-16　電話番号　局番

所在地　郵便番号 −

⑳ 傷病の部位及び状態 A-17

⑫の者については、⑲、⑱及び⑱に記載したとおりであることを証明します。　年 月 日

事業の名称 A-18　電話番号　局番

事業場の所在地 A-19　郵便番号 −

事業主の氏名 A-20　㊞

(法人その他の団体であるときはその名称及び代表者の氏名)

労働者の所属事業場の名称・所在地 A-21　電話番号　局番

(注意)　労働者の所属事業場の名称・所在地については，労働者が直接所属する事業場が一括適用の取扱いをしている支店、工場、工事現場等の場合に記載してください。

上記により療養補償給付たる療養の給付を請求します。　A-23 年 月 日

A-22 労働基準監督署長 殿

A-26 病院 診療所 薬局 訪問看護事業者 経由

請求人の　郵便番号 A-24 −　電話番号 A-25 局番

住所 A-27　(方)

氏名 A-28　A-29 ㊞

不支給決定決議書	署長	次長	課長	係長	係	決定年月日	・
						不支給の理由	
	調査年月日	・ ・	・ ・	・ ・			
	復命書番号	第 号	第 号	第 号			

折り曲げる場合には(◀)の所を谷に折りさらに２つ折りにしてください。

〔この欄は記入しないでください。〕

(物品番号 7210 6.11)

A - ❶ -----► 1. This form is the "Application for Benefit of Medical Treatment as a Medical compensation Benefit".

A - ❷ -----► 2. For the commuting accident, please claim with 「様式第 16 号の 3」(Form No.16-3)

A - ❸ -----► 3. Please enter the labar insurance number. Please confirm the number with the employer.

A - ❹ -----► 4. This is the column for the sex of the worker suffered from the accident. Please enter [1] for men and [3] for women.

A - ❺ -----► 5. Please enter the date of birth of the worker suffered from the accident. (The year in accordance with the japanese calendar.)

A - ❻ -----► 6. Please enter the date when the worker was injured or started showing the symptoms of the disease. (The year in accordance with the Japanese calendar.)

A - ❼ -----► 7. Please enter the name of the worker suffered from the accident.

A - ❽ -----► 8. Please enter how to read the worker's name in Japanese Katakana. (Please pronounce clearly the name to someone who can understand it and ask him/her to enter it.)

A - ❾ -----► 9. Please enter the age of the worker suffered from the accident.

A - ❿ -----► 10. Please enter the address of the worker suffered from the accident.

A - ⓫ -----► 11. Please enter the kind of job as specifically as possible in order to give a good explanation of the content of the work.

A - ⓬ -----► 12. Please enter precisely the time when the worker was injured or started showing the symptoms of the disease.

A - ⓭ -----► 13. Please enter the name of job of the person (other than the worker suffered from the accident who confirmed the fact of the occurrence of the accident.

A - ⓮ -----► 14. Please enter the name of the person (other than the worker suffered from the accident) who confirmed the fact of the occurrence of the accident.

A - ⓯ -----► 15. Please enter a distinct explanation of where the accident occurred; in what work the worker was engaged when it occurred;by what thing, or in what circumstance or condition and how the accident occurred.

A - ⓰&⓱ -----► 16&17. Column 16 is one to enter the name, location, etc. of the hospital and Column 17 is one to enter the part of body and the condition of injury or disease. But these Columns 16 and 17 are filled in by the hospital.

A - ⓲~⓴ -----► 18-20. These columns are ones for the employer to certify when and how the worker suffered from the accident. The certification is made for the employer to enter the name of the workplace in Column 18, the location of the workplace in Column 19 and the name of the employer in Column 20.

A - ㉑ -----► 21. Please enter in the case where the workplace to which the worker directly belongs is the branch office, plant or construction site which adopts the blanket coverage.

A - ㉒ -----► 22. Please enter the Labour Standards Inspection Office having jurisdiction over the workplace to which the worker directly belongs.

A - ㉓ -----► 23. Please enter the date of submission of the application.

A - ㉔ -----► 24. Please enter the postal code for the address of the claimant.

A - ㉕ -----► 25. Please enter the telephone number for the claimant.

A - ㉖ -----► 26. Please enter the name of the hospital.

A - ㉗ -----► 27. Please enter the address of the claimant.

A - ㉘ -----► 28. Please enter the name of the claimant.

A - ㉙ -----► 29. This is the column for sealing but signature wil also suffice.

-----► ● Please do not fill in the column with an asterisk (*).

-----► ● Please consult with the Labour Standards Inspection Office or the employer for any matters which you cannnot understand for filling in this form.

In the Case of Commuting Accident

様式16号の3（裏面）　B-❶　通勤災害に関する事項

㋑負傷又は発病の時刻	午 前 後 B-❷ 時 分頃	㋺災害発生の場所	B-❸
㋩災害発生の日の就業の場所	B-❹	㋥災害発生の日の就業開始の予定時刻又は就業終了の時刻	午 前 後 B-❺ 時 分頃
㋭災害発生の日に住居を離れた時刻	午 前 後 B-❻ 時 分頃	㋬災害発生の日に就業の場所を離れた時刻	午 前 後 B-❼ 時 分頃
㋣通常の通勤の経路、方法及び所要時間並びに災害発生の日に住居又は就業の場所から災害発生の場所に至った経路、方法、所要時間その他の状況	B-❽ B-❾ （通常の通勤所要時間 時間 分）		
㋠災害の原因及び発生状況	B-❿		
⑪現認者の 住所	B-⓫	電話番号	B-⓭ 局 番
⑪現認者の 氏名	B-⓬		

［項目記入にあたっての注意事項］

1　記入すべき事項のない欄又は記入枠は空欄のままとし、事項を選択する場合には該当事項を○で囲んでください。（ただし、❽欄及び❾欄の元号については該当番号を記入枠に記入してください。）

2　傷病年金の受給権者が当該傷病に係る療養の給付を請求する場合には、⑤労働保険番号欄に左詰めで年金証書番号を記入してください。また、⑨及び⑩は記入しないでください。

3　⑪は、請求人が健康保険の日雇特例被保険者でない場合には記載する必要はありません。

4　㋥は、災害が出勤の際に生じたものである場合には就業開始の予定時刻を、災害が退勤の際に生じたものである場合には就業終了の時刻を記載してください。

5　㋭は、災害が退勤の際に生じたものである場合には記載する必要はありません。

6　㋬は、災害が出勤の際に生じたものである場合には記載する必要はありません。

7　㋣は、通常の通勤の経路を図示し、災害発生の場所及び災害発生の日に住居又は就業の場所から災害発生の場所に至った経路を朱線等を用いてわかりやすく記載するとともに、その他の事項についてもできるだけ詳細に記載してください。

8　㋠は、どのような場所を、どのような方法で往復している際に、どのような物で又はどのような状況において、どのようにして災害が発生したかをわかりやすく記載してください。

［標準字体記入にあたっての注意事項］

□□□で表示された記入枠に記入する文字は、光学的文字読取装置で直接読取りを行いますので、以下の注意事項に従って、表面の右上に示す標準字体で記入してください。

1　筆記用具は黒ボールペンを使用し、記入枠からはみださないように書いてください。

2　「促音」「よう音」などは大きく書き、濁点、半濁点は1文字として書いてください。

（例）キッテ → キ ツ テ　　キョ → キ ヨ　　バ → ハ ゛

3　シ ツ ソ ン は斜の弧を書きはじめるとき、小さくカギをつけてください。

4　1 はカギをつけないで垂直に、4 の2本の縦線は上で閉じないで書いてください。

表面の記入枠を訂正したときの訂正印欄	削字 ㊞ 加字	社会保険労務士記載欄	作成年月日・提出代行者・事務代理者の表示	氏名	電話番号
				㊞	

B - ❶ ·····► 1. This form is the "Matters concerning Commuting Accident" which is the reverse page of the "Application for Benefit of Medical Treatment as a Medical Benefit". There is not the same column in 「様式第５号」(Form No.5) "Application for Benefit of Medical Treatment as Medical Compensation Benefit" on the previous page.

B - ❷ ·····► 2. Please enter the time when the worker was injured or started showing the symptoms of the disease.

B - ❸ ·····► 3. Please enter the place of occurrence of the accident.

B - ❹ ·····► 4. Please enter the place of engagement in work on the date of occurrence of the accident.

B - ❺ ·····► 5. In the case when the accident occurred at the time of commuting to the workplace, please enter the scheduled time of commencement of work. In case when the accident occurred at the time of way back from the workplace, please enter the closing time for the workplace.

B - ❻ ·····► 6. Please enter the time at which the worker left his/her residence. However, it is not required to enter if the accident occurred on the way back from the workplace.

B - ❼ ·····► 7. Please enter the time at which the worker left the workplace. However, it is not required to enter if the accident occurred on the way from the residence to the workplace.

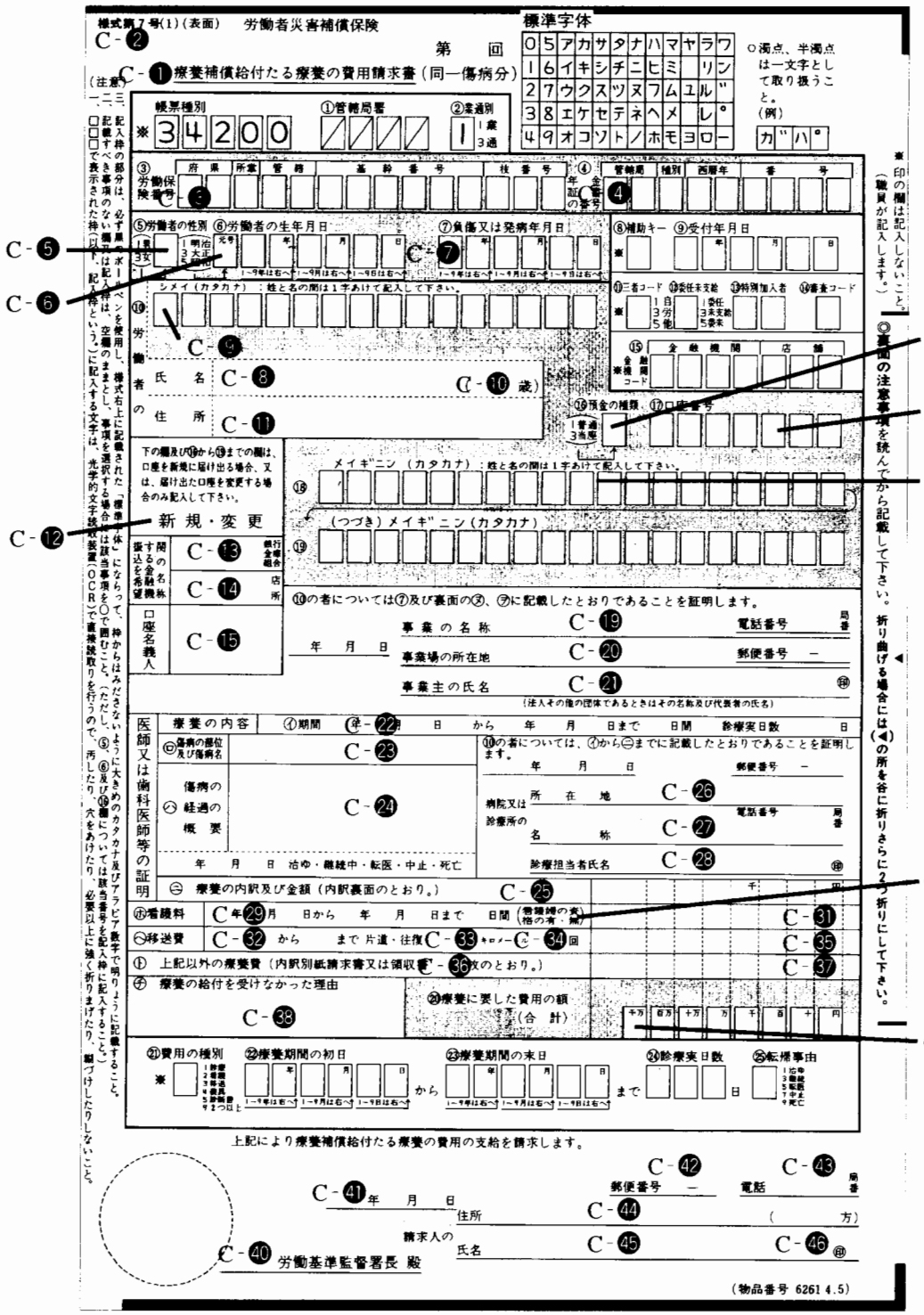
B - ❽ ·····► 8. Please illustrate the ordinary commuting route. Please enter clearly the place of occurrence of the accident and the route and means the worker took on the date of occurrence of the accident from the residence or the workplace to the place of occurrence of the accident.

B - ❾ ·····► 9. Please enter the time normally required for commuting.

B - ❿ ·····► 10. Please enter a distinct explanation of where the accident occurred; in what work the worker was engaged when it occurred; by what thing, or in what circumstance or condition and how the accident occurred.

B - ⓫~⓭ ·····► 11-13. This is the column to enter the person, if any, who confirmed the occurrence of the accident (other than the worker suffered from the accident). Please enter his/her address in Column 11, name in Column 12 and telephone number in Column 13.

Example of How to Fill in the Application



C - ❶ -----► 1. This form is the "Application for Payment of Medical Treatment Expenses as a medical Compensation Benefit".

C - ❷ -----► 2. In the case of commuting accident, the claim should be made with「様式第 16 号の 5(1)」(Form No.16-5(1)).

C - ❸ -----► 3. The column to enter the labour insurance number. Please confirm the number with the employer.

C - ❹ -----► 4. Please enter the annuity certificate number when receiving the annuity by the Workmen's Accident Compensation Insurance.

C - ❺ -----► 5. This is the column to enter the sex of the worker suffered from the accident. Enter [1] for men and [3] for women.

C - ❻ -----► 6. Please enter the date of birth of the worker suffered from the accident. (The year in accordance with the Japanese calendar.)

C - ❼ -----► 7. Please enter the date when the worker was injured or started showing the symptoms of the disease. (The year in accordance with the Japanese calendar.)

C - ❽ -----► 8. Please enter the name of the worker suffered from the accident.

C - ❾ -----► 9. Please enter how to read the worker's name in Japanese katakana. (Please pronounce clearly the name to someone who can understand it and ask him/her to enter it.)

C - ❿ -----► 10. Please enter the name of the worker suffered from the accident.

C - ⓫ -----► 11. Please enter the address of the worker suffered from the accident.

C - ⓬~⓲ -----► 12-18. These are columns for reporting the new account at financial institution for payment or chaging the account reported to other account. In Column 12, please circle「新規」for reporting the new account or「変更」for changing the account. Please enter the name of the financial institution in Column 13;the name of its branch in Column 14; and the name of holder of the account in Column 17 in Japanese katakana. In Column is 18, type of account, please enter [1] for the ordinary deposit and [3] for current account.

C - ⓳~㉑ -----► 19-21. These are columns for the employer to certify how and when the worker suffered from the accident. The certification is made by the employer to enter the name of the establishment in Column 19; the address of the employer in Column 20; and the name of the employer in column 21.

C - ㉒~㉘ -----► 22-28. These are columns to be filled in by medical doctor or dentist. The period of medical treatment is entered in Column 22; part(s) of body injured or contracted disease and name of injury or disease in Column 23; outline of progress of injury or disease in Column 24; and amount for medical treatment in Column 25. Column 26 is filled in with the location of the hospital or clinic; Column 27 the name of the hospital or clinic; and Column 28 the name of the person is charge of the trust expenses for medical treatment, etc.

C - ㉙~㉛ -----► 29-31. These columns are entered when the expenses for nursing care was paid. Please enter the period of nursing care in Column 29. In Column 30, if the person engaged in nursing care has the qualification of nurse, please circle「有」,and if he/she has no qualification, please circle「無」. Please enter the amount which was paid as the nursing expense in Column 31.

C - ㉜~㉟ -----► 32-35. There are columns to enter when the transportation expense was paid. Please enter the sectien for the transportation in Column 32; the distance of one way or both ways in Column 33; number of transportation in Column 34; and the amount paid as the transportation expense in Column 35.

C - ㊱&㊲ -----► 36-37. These columns are used when any expenses other than those mentioned above were paid. Please enter the number of bills or receipts which indicate the breakdown of the payment in Column 36 and the amount in Column 37.

C - ㊳ -----► 38. Please mention the reason why you have not received the medical treatment allowance.

C - ㊴ -----► 39. Please enter the total amount of expenses required for medical treatment (total of Columns 25, 32, 35 and 37).

C - ㊵ -----► 40. Please enter the Labour Standards Inspection Office which has jurisdiction over the workplace to which the worker belongs directly.

C - ㊶ -----► 41. Please enter the date of submission of the application.

C - ㊷ -----► 42. Please enter the postal code for the address of the claimant.

C - ㊸ -----► 43. Please enter the telephone number of the claimant.

C - ㊹ -----► 44. Please enter the address of the claimant.

C - ㊺ -----► 45. Please enter the name of the claimant.

C - ㊻ -----► 46. This is the column for sealing but signature will also suffice.

When the Designated Hospital, Etc. is Changed

D-❷
様式第6号

労働者災害補償保険

D-❶
療養補償給付たる療養の給付を受ける指定病院等(変更)届

D-❸ 労働基準監督署長 殿

D-❹ 年 月 日

(D-❺ 病院 診療所 薬局 訪問看護事業者 経由)

(郵便番号 D-❻)

住所 D-❼ 電話番号 D-❽ 局 番

届出人の 方

氏名 D-❾ D-❿ ㊞

下記により療養補償給付たる療養の給付を受ける指定病院等を（変更するので）届けます。

〔注意〕
一、事項を選択する場合には該当する事項を丸で囲むこと。
二、⑤は、◎どのような場所で、◎どのような作業をしているときに、◎どのような物・環境又は状態で、◎どのようにして災害が発生したかを、わかりやすく記載すること。
三、傷病補償年金の受給権者が当該傷病に係る療養に関しこの届書を提出するときは、(一)①及び④、(二)⑤は、記載する必要がないこと。事業主の証明は受ける必要がないこと。

① 労働保険番号										③ 労働者の	氏名 D-⓭ (男・女) D-⓮
府県	所掌	管轄	基幹番号				枝番号				生年月日 D-⓯ 年 月 日 (D-⓰ 歳)
											住所 D-⓱
② 年金証書の番号 D-⓬											職種 D-⓲
管轄局	種別	西暦年	番号								

④ 負傷又は発病年月日 D-⓳ 年 月 日 午前 午後 時 分頃

⑤ 災害の原因及び発生状況 D-⓴

③の者については、④及び⑤に記載したとおりであることを証明します。

年 月 日

事業の名称

郵便番号 - D-㉑

事業場の所在地 D-㉒ 電話番号 局 番

事業主の氏名 D-㉓ ㊞

（法人その他の団体であるときはその名称及び代表者の氏名）

⑥ 指定病院等の変更	変更前の	名称	D-㉔ (労災指定医療機関番号)
		所在地	D-㉕
	変更後の	名称	D-㉖
		所在地	D-㉗
	変更理由		D-㉘
⑦ 傷病補償年金の支給を受けることとなった後に療養の給付を受けようとする指定病院等の		名称	D-㉙
		所在地	D-㉚
⑧ 傷病名			D-㉛

(物品番号 6213) 10.2.

D - ❶ -----► 1. This is the form of "Notice of the (Change of) Designated Hospital, etc. at Which the Benefit of Medical Treatment as a Medical Benefit is to be Received".

D - ❷ -----► 2. Please use 「様式第 16 号の 4」(Form NO.16 - 4) in the case of commuting accident.

D - ❸ -----► 3. Please enter the Labour Standards Inspection Office which has jurisdiction over the work-place to which the worker directly belongs.

D - ❹ -----► 4. Please enter the date of submission of the Notice.

D - ❺ -----► 5. Please enter the hospital after change.

D - ❻ -----► 6. Please enter the postal code for the address of the claimant.

D - ❼ -----► 7. Please enter the address of the claimant.

D - ❽ -----► 8. Please enter the telephone number for the claimant.

D - ❾ -----► 9. Please enter the name of the claimant.

D - ❿ -----► 10. This if for sealing but signature will also suffice.

D - ⓫ -----► 11. The is the column for entering the labour insurance number. Please confirm the number with the employer.

D - ⓬ -----► 12. Please enter the annuity certificate number when the worker is receiving the annuity by the Workmen's Accident Compensation Insurance.

D - ⓭ -----► 13. Please enter the name of the worker suffered from the accident.

D - ⓮ -----► 14. Please circle the sex of the worker suffered from the accident.Circle「男」for men and「女」for women.

D - ⓯ -----► 15. Please enter the date of birth of the worker suffered from the accident.

D - ⓰ -----► 16. Please enter the age of the worker suffered from the accident.

D - ⓱ -----► 17. Please enter the address of the worker suffered from the accident.

D - ⓲ -----► 18. Please enter the kind of job as specifically as possible in order to give a good explanation of the content of the work.

D - ⓳ -----► 19. Please enter the date and time when the worker was injured or started showing the symp-toms of the disease.

D - ⓴ -----► 20. Please enter a distinct explanation of where the accident occurred; in what work the worker was engaged when it occurred; by what thing, or in what circumstance or condition and how the accident occurred.

D - ㉑~㉓ -----► 21-23. These are columns for the employer to certify how and when the worker suffered from the accident. The certification is made by the employer to enter the name of the establishment in Column 21; the address of the employer in Column 22; and the name of the employer in Column 21.

D - ㉔ -----► 24. Please enter the name of the designated hospital,etc. before change.

D - ㉕ -----► 25. Please enter the location of the designated hospital, etc. before change.

D - ㉖ -----► 26. Please enter the name of designated hospital, etc. after change.

D - ㉗ -----► 27. Please enter the location of designated hospital, etc. after change.

D - ㉘ -----► 28. Please enter the reason for change of the designated hospital etc.

D - ㉙&㉚ -----► 29-30. Please enter the name of the designated hospital, etc. to receive the medical treatment benefit after the start of receiving the injury of disease compensation annuity in Column 29 and the location of the hospital in Column 30.

D - ㉛ -----► 31. Please enter the name of injury or disease.