Example

K-601 | P （P　　）

日立健康保険組合　御中

健康保険 限度額適用認定申請書

Request for issuance of Maximum Co-payment Certificate for Health Insurance

【Please check before applying】

1. **Please check with the medical institution in advance if a Certificate of Application of Maximum Copayment Amount is required.**
2. We recommend using a Myna health insurance card. Using this card will eliminate the need to apply in advance for a Certificate of Application of Maximum Copayment Amount. And then, you will be exempt from payments beyond the maximum copayment amount under the High-Cost Medical Care Benefits system.
3. If you are **70 years old or older and your copayment ratio is 20%, you do not need to apply for the certificate**.

※太枠線内をご記入ください。（記入要領等は、別紙「記入例」をご参照ください）

1 被保険者	提出日 Submission date	令和 ○○ 年 ○○ 月 ○○ 日 Year Month Date	備　考	
	被保険者等記号・番号 Insured person's ic code and number	記号 1000 番号 10000000	被保険者氏名 Name of insured person	(ﾌﾘｶﾞﾅ) ケンポ　マサミ 健保　正美
	事業所(会社)名称 Office (company) name	株式会社○○○○○	所属・電話 Affiliation and telephone number	○○課 (TEL： 000-000-0000)
2	被保険者住所 Contact Address	〒 000 － 0000 ○○県○○市○○町１－１－１ (TEL： 000 － 000 － 0000) ※平日の日中にご連絡可能な番号をご記入ください		
3	対象者氏名(療養を受ける人) Name of subject person	(ﾌﾘｶﾞﾅ) ケンポ　マサミ 健保　正美	被保険者との続柄 Relationship	本人
	生年月日 Date of Birth	昭和 平成 令和 5 5 年 0 4 月 0 1 日		
証	発効希望月 (いずれかに✔) Requested effective month	☑ 当月（提出日の属する月）より有効の認定証を希望 Certificate valid beginning with the current month (month including application date) requested ☐ 翌月より有効の認定証を希望 Certificate valid beginning with the following month requested		
4	対象者の傷病の原因 (いずれかに✔)	1. 第三者の行為(交通事故・暴力行為等)に該当しますか？ Was it due to the actions of a third party (e.g., traffic accident, act of violence)? ☐ はい(Yes) ☑ いいえ (No) 2. 通勤途中または業務中のものですか？ Did it occur while commuting or on the job? ☐ はい(Yes) ☑ いいえ (No) ※上記1または2で「はい」に該当する方は、事前に当健保組合までご連絡ください If you answered "Yes" to 1 or 2 above, contact the Health Insurance Society before applying.		
5	医療費助成の有無 (いずれかに✔)	If you select "No", you do not need to fill in ⑥. 国や地方自治体から、医療費助成を受けていますか？ Did you receive medical assistance from a national or local government or other agency for all or part of the costs you paid at the counter of hospitals? ☐ はい Yes ☑ いいえ No ☐ 申請中 Application in process		
対象者	医療費 助成制度の名称 (いずれかに✔) Name of assistance program	☐ Medical care for severe mentally and physically handicapped people ☐ Medical care for children ☐ Medical care for single-parent households, etc. ☐ Other (　　) ☐ Medical care for specific disease		
6	受給者証を交付した市区町村名(都道府県名) Name of municipality (or prefecture) that issued the beneficiary card		公費負担者番号(８桁) Public expenditure provider no.	
	受給者証の有効期間 Period of validity of beneficiary card	令和 年 月 日 ～ 令和 年 月 日 Year Month Date		
7	認定証の送付先 ※被保険者住所と同じ場合は記入不要です	〒 － Where to send the certificate * Enter if this address differs from the above address		
	受取人氏名	Recipient Name	被保険者との続柄 Relationship	受取人連絡先 TEL：

If you select "Yes" or "Application in process", fill in ⑥.

If you wish to have the certificate sent to a hospital, please fill in the address of the hospital, **hospital name, ward, and room number**.

※認定証は、「簡易書留」にて送付いたします。
※限度額適用認定証の有効期限は、発効月の1日より**最長6ヶ月**です。

Use this application form in the following circumstances:

When applying for issuance of a Maximum Copayment Certificate

 # About the high-cost medical expenses benefit

If the copayment amount paid at the reception desk of the hospital becomes high due to hospitalization, etc., there is a **system that can reduce the copayment to the maximum amount of the copayment for high-cost medical expenses as shown in the table below**.

Maximum amount of copayment for high-cost medical expenses: Persons who meet the conditions described in the following table can apply for the Certificate of Application of Maximum Copayment Amount.

Eligible person	Standard monthly remuneration	Maximum amount of copayment per month	4th and subsequent months	Classification
Persons under 70 years old	830,000 yen or more	252,600 yen ＋ (medical care costs - 842,000 yen) *1%	140,100 yen	ア
	530,000 yen - 790,000 yen	167,400 yen ＋ (medical care costs - 558,000 yen) *1%	93,000 yen	イ
	280,000 yen - 500,000 yen	80,100 yen ＋ (medical care costs - 267,000 yen) *1%	44,400 yen	ウ
	260,000 yen or less	57,600 yen	44,400 yen	エ

Eligible person	Standard monthly remuneration	Maximum amount of copayment per month	4th and subsequent months	Classification
Persons 70 years old and older with a copayment ratio of 30%	530,000 yen - 790,000 yen	167,400 yen ＋ (medical care costs－558,000 yen)*1%	93,000 yen	現役並みⅡ
	280,000 yen - 500,000 yen	80,100 yen ＋ (medical care costs－267,000 yen)*1%	44,400 yen	現役並みⅠ

◆ Cautionary notes

① If you do not use this system, you will have to pay the copayment (30%, etc.) at the reception desk of the hospital. However, your **final copayment amount will remain the same**, as high-cost medical expenses and additional amounts will be automatically paid after 3 or later months from the month of medical treatment.

② **If you are 70 years old or older and meet the following conditions, you do not need to apply for the Maximum Copayment Certificate.**

Employees or family members dependent on the insured person,individuals and family members of a Voluntarily and Continuously Insured Person:
- Persons whose copayment ratio is **30%** and standard monthly remuneration is **830,000 yen or more**
- Persons whose copayment ratio is **20%**

Individuals and family members of a Special-Case Retired Insured Person :
- Persons whose copayment ratio is **20%**

◆ How to fill in the form (match the number to the example entry)

① Enter the submission date.
② Fill in the address where the insured person resides.
③ Fill in the name, relationship, and date of birth of **the person receiving medical treatment.**
④ Fill in a check mark (✔) in the applicable box.
 # If you select "Yes", please contact the Health Insurance Society in advance.
⑤ Fill in a check mark (✔) in the applicable box.
⑥ If you select "Yes" or "Application in process" in ⑤, fill in the details of the grant.
⑦ Fill in the address only if it is different from the address of the insured person.

Note: When correcting the information you entered, draw a double line through the information to be corrected and enter the correct information and the name of the insured person.

◆ Address for Submission

Submit to the health insurance association.
Please send it to the address below.
Hitachi Health Insurance Society　Operations (Benefits)
Higashi-Ochanomizu Building, 2-29, Kanda Awaji-cho, Chiyoda-ku, Tokyo, 101-0063

To minimize the chance of documents being lost, we recommend that you use registered mail or similar means.