Example

常務理事	事務長	担当	係

健康保険 Health Insurance 移送承認申請書・移送届

被保険者 Insured Person / 家族 Family Member

Application Form for Approval of Transportation Expenses / Notification of Transportation

※記号・番号が不明の場合は、番号欄に社員番号をご記入ください *If the Symbol/Number is unknown, please fill in your employee number in the number field.

被保険者が記入するところ To be Completed by Insured Person

① 被保険者等の記号番号 Insured Person's Symbol/Number		② 被保険者(申請者)の氏名 Name of Insured Person (Applicant)	③ 被保険者の生年月日 Birth Date of Insured Person
記号 Symbol	番号 Number		
1234	12345678	John Smith	1975年 YYYY 6月 MM 1日 DD

④ 被保険者(申請者)の住所 Address of Insured Person (Applicant)	〒 Please fill in your current address.		
家族が移送を受けたときはその者 When a family member has received transport: That person	⑤ 該当者氏名 Name of Applicable Person	⑥続柄 Relationship	⑦ 該当家族の生年月日 Birth Date of Applicable Family Member
	Jack Smith	Eldest son	2001年 YYYY 9月 MM 1日 DD

⑧ 事業所の Workplace's	所在地 Location	Please fill in your name of company
	名称 Name	
⑨ 傷病名 Name of Illness or Injury		If applying for a child, do not simply write " Child " as the relationship. Instead, write "Eldest son", "Eldest daughter",
⑩ 発病または負傷の原因を詳しく Cause of Illness or Injury (be specific)	Unknown	For traumatic injuries or illnesses, please provide detailed information about the cause of injury.
⑪ 負傷原因が第三者により生じたものですか Caused by a Third-party ?		
⑫ 移送を必要とする Need for Transport	理由 Reason	*** Hospital had insufficient treatment facilities for ***, and transfer to *** Hospital with adequate treatment facilities was necessary. However, due to the patient's difficulty with moving, transport assistance was required.
	区間回数 Route and frequency	** Hospital から from **** Hospital まで to 1 回 time(s)
⑬ 移送をする前に提出できなかったときはその理由 Reason for inability to submit prior to transport		Due to the emergency nature of the required transport, this form is being submitted after the transport was carried out.

医師が記入するところ To be Completed by Doctor

⑭ 傷病名 Name of Illness or Injury		
⑮ 必要と認めた移送の Transport Deemed Necessary	方法 Method	
	区間回数 Route and frequency	から from まで to 回 time(s)
⑯ 移送を必要と認めた理由 Reason transport was		

Ask for certification from a doctor who recognized the transfer as necessary.

*Pleas

うえの 記載で移送の必要を認めます。

I hereby certify that transport was necessary for the reasons stated above.

年 YYYY 月 MM 日 DD

医師の Doctor's
住所(所在地) Address (Location) of the medical care institution
保険医療機関名 Name of the medical care institution
氏名 Name

※医療機関名等ゴム印を押印ください。
* Please stamp the name of the medical care institution, etc.

受取日付印

FR健康保険組合〔R7.1〕
FR Health Insurance Organization (January, 2025)