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INTRODUCTION AND GENERAL SUMMARY of the Social Security Report

Social security legislation is designed to protect individuals against the economic effects of certain major risks of life. Among such risks are loss of earnings because of temporary or permanent disability or involuntary unemployment, expenses for medical care, loss of the breadwinner in the family, and dependency in old age. This protection is important to the individual because he cannot predict when he will suffer such a loss or cannot alone make adequate provision for meeting it.

Especially as a nation becomes industrialized and means of livelihood become more and more beyond the control of the individual, social security legislation becomes necessary to prevent unrest and maintain stability in the economic, political, and social structure. The ability of individuals to maintain an acceptable standard of livelihood, through social security institutions which are responsive to the popular will, adds to their confidence in their government and in their society.

Social security legislation also has the effect of creating conditions favorable to the exercise of initiative and enterprise and is therefore an important ingredient of democracy. As it protects the individual against the unpredictable, the results of his own thrift or risk-taking are safeguarded, he competes on more equal terms, and he finds it worthwhile to practice thrift and to exercise fully his ability and resourcefulness.

The relationship between stable government and the prevention of unrest due to economic distress is recognized by Article 25 of the new Japanese Constitution, which provides that, "All people shall have the right to maintain the minimum standards of wholesome and cultured living. In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health."

Japanese social security systems have been developed over many decades to become an important part of the economic and social fabric of the country. In 1944 more than two-thirds of the population were protected by some form of social insurance. In the medical profession eighty percent of private practitioners were "insurance doctors". Ten percent of the hospital beds were in hospitals owned and operated by insurance institutions. In 1946 over 1.7 billion yen were paid out as compensation for temporary and permanent disability and for medical care and over two hundred and fifty million yen as retirement pensions or allowances and survivors' benefits.

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The end of the war, bringing with it substantial reductions in production and employment, resulted in sharp reductions in the coverage of these programs and in the volume of benefits payable under them. Nevertheless, in many respects advances in the program have also been made since the war. The most important advance in social security is embodied in the Daily Life (or Livelihood) Security Act, enacted in October 1946, which, while still suffering from inadequate appropriations, provides a comprehensive, non-categorical assistance program that can be considered one of the most advanced in the world. Adjustments have been made in individual social insurance programs to establish appeals machinery and advisory councils. The coverage of the Seamen's Insurance system has been more than doubled. Improvements have been made in various areas of administration of the social insurances. Legislation establishing a system of unemployment allowances and insurance is now being considered by the Diet.

From the beginning of the Occupation, however, it was apparent that the social security programs were urgently in need of a thorough review, and, with the advance of inflation in this country, that need became more pressing.

The social security programs had been so established over a period of decades that the resulting pattern of social insurance provides duplicatory protection in some respects, inconsistencies and anomolies, income deficits in some programs, and excessive income in relation to benefits paid in others. Furthermore, the development of medical services rendered by insurance institutions had resulted in a confusion of public and private responsibilities and an uneconomic use of medical care facilities. Throughout, undemocratic systems were operating under the authority of the government but not responsible to the public will. A reformulation of these programs, covering their administrative organization as well as their substantive provisions, obviously would result in a more effective use of existing social insurance resources, assist in placing the Japanese economy on a sound basis, and advance the establishment of democratic institutions.

Post-war economic conditions, especially the alarming inflation, constitute an even more serious problem. The full effect of inflation is offset somewhat, to the extent that wages and payrolls move up with prices, so that income, based on payrolls, and benefits, determined as a proportion of recent wages, rise as prices rise. However, there are a number of factors limiting such an offset. Wages do not go up as fast or as far as prices. There are certain limits in the laws as to the maximum monthly wage taxable: in the Welfare Pension program it is ¥600 and in Health Insurance ¥2000, although in the Seamen's Insurance it has now risen to ¥8000 and the limit being proposed

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for Unemployment Insurance is ¥5100. The wage classes used to establish the amount of benefits have a cut-off at the top which does not permit a full reflection of increased rates of pay on either contributions or benefits.

Inflation has a more serious effect on the adequacy of those benefits which are based on wages earned when wage levels were much lower. Such benefits are characteristically those taking the form of pensions for old age and invalidity. Furthermore, upward adjustments in the amounts of such benefits which are, or are certain to become, necessary have the inevitable result of making reserves, previously accumulated, completely inadequate to meet the increased liability of the funds for the payment of benefits. In fact, as long as inflation is not halted, the continuing accumulation of reserves becomes highly questionable.

The rise of prices has also a direct effect on social insurance programs which provide benefits in the form of medical care and drugs and especially where, as in National Health Insurance, the income for the program is not related to payrolls. The rapid increase in the rates of compensation required by doctors (induced in part by the scarcity of drugs and the increased cost of the available supply) has resulted in widespread suspension of National Health Insurance Associations because of the inability or unwillingness of the memberships to raise membership fees to the extent necessary to meet these increased costs. More economical methods for providing medical care, e.g., through association-owned or controlled clinics, have been difficult to adopt because of the scarcity and high costs of building materials and equipment. Inflation also raises obstacles to even normal government assistance. Rising costs make it difficult to maintain government revenues at a level approaching expenditures, increase the tax payer's resistance to levies requiring a higher proportion of his income, and increase the economic dangers of deficit financing which is itself inflationary.

Early in the period of Occupation it became evident that there was a need for SCAP policy to (1) strengthen and rationalize the existing social security systems and place them on a sound financial basis so that they will cease to be a drain on the economy and can withstand the shock caused by the inflation; (2) guide the extension of social security protection into those areas and to those people for which it is needful and appropriate; (3) guide the development of a public hospital policy, especially in view of the necessity to abolish the semi-official Japanese Medical Treatment Corporation; (4) assure the maximum use of medical facilities in supplying medical care to the Japanese people; (5) guide the development of a proper function for the organized medical profession in the administration of the health insurances.

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In early 1946 a Labor Advisory Committee to SCAP made a survey of the Japanese social insurance programs. In its report, dated May 1946, it recommended that steps be taken to: 1) maintain the social insurances during the period of currency inflation; 2) adopt specific measures affecting Health Insurance and National Health Insurance to assure the provision of medical treatment for which these systems were considered indispensable; 3) study the extension of coverage to groups not insured under existing programs. The Committee, finding a serious lack of coordination in existing programs and problems susceptible to treatment only in terms of fundamental revisions in the program, expressed the view that a comprehensive reform of social insurance could and should be undertaken and that machinery should immediately be set up to plan such reforms.

At about the same time the Japanese Committee for the Investigation of the Social Insurances was established by the Japanese Cabinet, with membership drawn from labor, employers, the faculties of leading universities in Japan, and officials of the Japanese Government. This committee made studies of the Japanese systems and in early 1947 made proposals for a complete reorganization and comprehensive expansion of the Japanese social security system. These proposals were issued in revised form in October 1947. The proposals of this Committee were strongly influenced by developments within the last five years regarding social security programs in democratic countries throughout the world.

In March 1947 the Japanese Government also formed a Council on Medical Treatment charged with recommending improvements in medical care and medical education, suggesting plans for utilization or disposing of the properties of the Japan Medical Treatment Corporation, and studying improvements needed in health insurance.

Within the last year, principally because of the continued rise in the cost of medical care together with the inherent weakness of small, financially autonomous insurance units, increasing numbers of National Health Insurance Associations, perhaps totalling 4,000 out of a total of 10,000, have suspended payments for medical care, and reserves of all systems have become so seriously impaired as to be no longer meaningful in the light of their original function.

Consequently, there has developed wide-spread demand for renovation of existing systems so that medical services will be available fully to insured people and that the payment of cash benefits will be assured for wage loss due to disability or unemployment, for old age, or for loss of the breadwinner in the family.

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It is in the light of these conditions that the visit of the present Social Security Mission must be viewed. The Mission has had only approximately sixty days in which to analyze the problems and make its recommendations. However, it has had the advantage of the work previously done in the field by the Public Health and Welfare Section and by the Labor Division of the Economic and Scientific Section and the studies made by official Japanese committees. The Mission has been able to observe the operation of various types of representative insurance and medical care facilities, rural and urban, in the vicinity of Tokyo and in the Kyoto-Kobe area. It has met with representatives of employers, employees, the medical professions, the federations of societies and associations, and the Social Insurance Investigating Committee and the Council on Medical Treatment. 1/ The Mission, therefore, feels that it has acquired such information as is available on the operation of existing systems of social security and on the body of opinion in Japan concerning them.

The Mission in making its recommendations has been strongly influenced by two major conflicting considerations. On the one hand, the Japanese nation has had a long period of experience with almost every form of social security and now shows an eagerness to utilize fully these social institutions in a democratic manner to assure to the population a minimum standard of livelihood and welfare. At the same time, the experience of the Japanese has revealed fundamental weaknesses, especially in administrative relationships essential to the success of any kind of social insurance program. These weaknesses, together with the present condition of the physical, financial, and technical resources of the country, suggest deliberative action directed to the development of sound practices and the rehabilitation of those forms of social security for which the Japanese Government has already accepted responsibility.

1/ Appendix A is a list of the representatives who were consulted.

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SUMMARY OF RECOMMENDATIONS

The recommendations of the Social Security Mission may be summarized as follows:

1. For the groups - industrial, commercial, maritime, and governmental - now covered by compulsory systems for old age, survivors, and wage loss due to disability (and unemployment), one system should provide for:

a. Old age benefits at age sixty (for women, possibly at 55) for those who have had at least ten years in covered employment, in amounts varying with previous wages, length of service, and number of dependents. Pensions now being paid would be recalculated on the new schedule. Periods of employment already credited under existing systems would count in determining the qualifications of individuals under the new. To the extent that liability of existing Mutual Aid associations or the Seamen's Insurance system for existing or future benefits is assumed by the new system, reserves against such liability should be taken over.

b. Invalidity benefits, which, for occupational cases, would require no qualifying term of coverage. Invalidity resulting from other than occupational reasons would be compensable only to individuals who have met the requirement of previous employment necessary to qualify for old age benefits, or less if they can show recent attachment to labor force. In addition, an allowance should be payable for dependents.

c. Survivors' benefits, payable in occupational cases regardless of length of service but, when death is due to other than occupational causes, upon proof of attachment to the labor market as required for invalidity compensation.

d. Benefits for temporary wage loss due to disability or unemployment payable to those attached to the labor force. Benefit level for non-occupational disability and unemployment would be the same; a higher level should be provided for occupational disability. Dependents' benefits should also be payable. In the case of working women, wage-loss due to maternity would likewise be compensable.

e. Medical care for insured individuals and their dependents to the full extent required; maternity benefits, in the form of a cash allowance for special expenses incident to childbirth, for wives of employed men as well as for employed women. The existing form of administration through societies should be strengthened financially by providing for some pooling of funds to equalize costs and should be strengthened administratively by delegating greater authority to the societies to make arrangements with doctors and medical facilities, by creating greater supervision by the government over the societies, by decentralization of administration of Government-managed health insurance, and

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by giving doctors freedom to participate or not to participate under negotiated terms of service. There should also be a thorough exploration of methods for compensating doctors as alternatives to the present fee-for-service method.

Employees in establishments with less than five employees should receive the same protection as those in establishments of five or more.

Economic insecurity arising out of the number of dependents relying on one wage-earner's income is now dealt with to a high degree by the incorporation of family allowances in the system of wage payment in Japanese industry. It is suggested that serious consideration be given to the rationalization of the existing wage structure by excluding such allowances from wages and by having the government assume the obligation of paying family allowances on a uniform basis. With the adoption of this plan, dependents' benefits payable to insurance beneficiaries should be made consistent with the family allowances payable to employed persons.

It is proposed that the protection which would be given for the risks described above be given under one basic system, having as its objective subjecting employers and employees to only one social security tax, having only one agency or office with which an employer or insured person will have to deal, simplifying forms and procedures and reducing administrative costs. However, it is not proposed that voluntary associations, existing or organized in the future, be prohibited or even discouraged from providing cash benefits in excess of those prescribed in the basic plan.

The total number of persons insured under this proposal would be approximately 7.5 million. This total would be composed as follows: 5.2 million in commerce and industry; 2.3 million persons in public employment and government enterprise. Since it is proposed that benefits be provided for dependents and survivors of insured, the total number of persons receiving protection would be approximately 25 million.

2. For the groups not now subject to an obligatory social security system but for whom protection against the costs of medical care is available through prepayment - largely on a voluntary basis - the existing system should be strengthened by requiring that the prepayment medical care plans adopted by prefectures, cities, towns, and villages:

a. Be adopted by election as applicable to all in the community not covered by other health insurance plans;

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b. Cover a sufficient number of people to permit the operation of the insurance principle.

c. Provide for paying the full costs of medical care, insofar as those costs would otherwise have to be met by insured people as individuals.

d. Provide for its financing by an income reasonably calculated to pay for the services required.

e. Permit the prefectural government to integrate public health activities with those of the community prepayment plan.

For such community health insurance plans a system of grants-in-aid should be developed, designed to contribute from national funds a portion of the cost of medical care, related to the amount which the community itself is meeting, but varying inversely with community resources as measured by per capita income. Funds provided for the establishment and operation of public medical facilities would be regarded as a part of the total grant-in-aid made available to the community.

3. For all people of Japan, but especially for those insured people relying for medical care on existing prepayment systems:

a. The public service character of hospitals must be recognized.

b. A nation-wide system of hospitals should be developed in accordance with one over-all plan.

c. The capital cost of the hospital program should be borne from public funds, primarily from national funds, but as much local autonomy as possible should be permitted to encourage the development of institutions suited to local needs.

d. A substantial portion of the operating expenses of hospitals should be met from public funds.

e. Hospital staff policy should be directed toward improving professional service.

f. Standards for hospitals should be enforced by a licensing system.

g. Adequate allocations of food should be made to hospitals.

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h. Gradual development of a midwifery service as a public function.

i. Public health functions of government should be developed through a consistent pattern of national, prefectural, and local administration. However, services of a public health nature should be fully coordinated with the activities of health insurance institutions. Under suitable circumstances nurses performing substantial elements of the public health program may be assigned to work with a community health insurance plan, but the public health program should be maintained in a consistent pattern through the employment and direction of such public health nurses by prefectural authorities.

4. For those not protected or not sufficiently protected by social insurance, the non-categorical type of public assistance program now provided by the Daily Life Security Law is endorsed. No segmentation of this program is recommended or considered desirable.

5. The administrative structure should be revised by providing for:

a. The establishment of a representative advisory council on the level of the Cabinet to advise the Diet and the responsible administrative agency on planning, policy, and legislation with regard to social security.

b. The delegation by the Diet to a single ministry, of which the choice of the Ministry of Welfare would seem most appropriate, of full authority and responsibility for the administration of the social security program in Japan. The delegation should direct that administrative functions be diffused on a decentralized, local basis to accord with democratic principles and that full utilization be made of local advisory councils. Further, full coordination of all social security functions within the ministry should be required. However, full administrative responsibility must be retained and final authority must be exercised by the ministry.

c. An independent appeal structure of quasi-judicial nature should be established to provide a fair hearing to all interested parties when desired on any determination involving social insurances protection, subject to final appeal to the regular courts.

These recommendations, with the analysis which leads to them, are spelled out in Part II of this report. Part I describes the existing social security programs and the medical and public health services and facilities associated with them.

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In the preparation of this report the Mission has had invaluable assistance and constructive criticism from all parts of the Public Health and Welfare Section, most particularly by the Social Security Division. That Division prepared most of Part I of the report.

Try to supplement this from the field

Procedures Currently in Use in Connection with the Examination of Doctors' and Dentists' Bills for Treatment Rendered Under the Social Insurances

I. Social Insurance Medical Fee Payment Fund

The detailed procedure of examining, clearing (or disallowing) and paying doctors' bills, and of collecting deposits from the insurers is done at present in the following steps and with the help of the ledgers and forms enumerated below.

A. Doctors' and dentists' bills are submitted on standard forms (see enclosures A and B) by the fifth of each month. They remain in the original order (in small bundles as submitted by each doctor) throughout the process of examination and review described below.

B. The first step in the examination procedure consists in a check by the clerical staff of the correctness of the point values used by the doctor or dentist and his arithmetic. Thereupon, the clerks prepare a summary sheet (standard form, see enclosure C) for each doctor, listing on it the number of cases and days of treatment for which compensation is asked by the doctor. These forms are for the use of the Review and Auditing Committee in making its check. The duration of this preliminary clerical routine review varies according to the number of claims in a given prefecture and the size of the staff, from about two days upward each month.

C. Next, the checked bills as corrected are routed, in the original bundles but with one of the said summary sheets attached to each bundle, to the Reviewing and Auditing Committee for the purpose of determining whether the treatment given and charges made therefor by the doctor are appropriate and reasonable judging from the nature of the illness(es) listed on the bill. In committee, the bundles of bills are divided among the members, each doctor examining the claims submitted by the doctors of one or more cities, towns or rural areas. Any disallowances on professional grounds are noted on the respective bills which are then returned to the clerical staff for further processing with summary annotations by the examiner on each bundle. Again, the duration of this phase of the examination varies according to the volume of bills, from about two to seven days each months.

D. The subsequent processing of the bills for payment is the most time-consuming phase of all, owing to a variety of clerical operations consuming from one to three weeks. First each doctor's bills as approved by the Reviewing and Auditing Committee are summarized on the summary sheet of paper referred to above which will now be completed to show the total number of cases and days claimed, the total number of points and total payment approved, grouped according to the type of insurer (Health Insurance under society management, Seamen's Insurance, Mutual Aid Associations, National Health Insurance) responsible for payment. From these sheets total amounts requested and total amounts approved are then transcribed into a ledger in which an individual

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E. At the same time the above data are transferred to the said ledgers for record and accounting purposes, three types of statement are prepared for action purposes:

1. The total cost of social insurance medical care rendered by each doctor and dentist in the given month plus the administrative cost (1.8 points per case) are added up for each insurance carrier or branch

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thereof (standard form, see enclosure D), and mailed, together with all doctors' bills covered by it (for purposes of control and possible correction by the insurer) ideally not later than the 20th of the month in which these doctors' bills were received, to the insurance carrier with a request to the addressee to remit an equivalent amount to the branch office of the Fund not later than by the 25th of the same month in order to permit payment to the doctors and dentists by the end of the month.

Whenever a doctor's bill is chargeable to an insurance carrier or branch in another prefecture,--by reason of the fact that an insured who received treatment in the given prefecture was employed in another and therefore paid his contributions there--the request for payment of the amount due used to go to the local branch, if any, of the insurer which would forward it to the branch in question or to the insurer's central paying office maintained by some of the Health Insurance Societies and Mutual Aid Associations with branches all over the country. This practice caused considerable delay and consequent complaints by the doctors. Therefore, since April 1949, the practice was changed and statements of the above description are now sent directly to the branch office of the insurance carrier to which the claim is chargeable. Some insurers have accepted this revised procedure with ensuing short-cut of up to three months in the time required to obtain deposit. Others have insisted however, that for reasons of uniformity in their book-keeping procedure the notice of deposits due sent by a prefectural branch office of the Fund must contain all doctors' bills originating in that prefecture.

2. Meanwhile, pending receipt of the money from the insurers (including the government which occupies that position under the government-managed part of Health Insurance and under Seamen's Insurance) statements are prepared (standard form, see enclosure E) to be sent to each of the doctors immediately upon receipt of the moneys and advising them of the total number of cases. In the past, these notifications to the doctors did not contain a statement or explanation as to claims disallowed by the Reviewing and Auditing Committee (except in cases of a major disallowance which would be noted in the "Remarks" column) except as evident from the difference between the amounts requested by the doctor and the amount received. Also in cases of delayed deposit by some insurers, there has been no advice given to the doctor which insurer has failed to make the deposit. Both practices have given rise to complaints by the doctors.

   Likewise pending receipt of the deposits to be made by the insurers' notifications to the bank and its local branches are prepared (standard form, see enclosure F) to be sent off immediately upon receipt of said deposits advising the bank or local branch to credit specified amounts to the doctors' accounts identified by name and number.

II. Institutions and Procedures for the Payment of Doctors' Bills Chargeable to Insurers not now Cooperating with the Social Insurance Medical Fee Payment Fund

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II. Institutions and Procedures for the Payment of Doctors' Bills Chargeable to Insurers not now Cooperating with the Social Insurance Medical Fee Payment Fund

A. Under National Health Insurance

Although eligible for membership in the Fund and expected eventually to become members, the National Health Insurance carriers have remained outside the Fund. The major reasons given therefor are the alleged administrative difficulties due to the number and claims load of National Health Insurance carriers, their financial insecurity and instability. Instead, many prefectures have established a separate mechanism for examining and paying doctors' bills pursuant to a Welfare Ministry directive (Hohatsu No. 56 of Sept. 24, 1948 establishing the National Health Insurance Central Reviewing Committees--Kokumin Keno Hoken Shinryo Chosai Kyogi Kai.)

In one prefecture a National Health Insurance Medical Fee Adjustment Committee (Kokumin Kenko Hoken Shinryo Chosai Kyogikai) composed of representatives of

The law as amended on 30 May 1949 provides that each insurer should deposit every month in advance "1½ times the highest sum required during any of the past three months." However, some insurers, especially the government, have been slow to comply with this stipulation and instead insist on the rendering of an itemized bill prior to making their deposits and on limiting these to the amounts billed.

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the purveyors of medical care, National Health Insurance carriers and insured examines and certifies or disallows--all doctors' bills submitted for that purpose by the insurance carriers. The members, who are not all doctors, receive no salary other than a per diem of ¥120, a hotel allowance (¥400-¥500 per night) and refund of travel expenses. The Committee meets for one day per month and review about 1500 doctors' bills submitted for review. (Not all National Health Insurance carriers availed themselves of its services.) However, this Committee has nothing whatever to do with the payment of these bills. Rather, the insurer pays the bill directly to the doctor, ideally immediately upon receipt of the bill and relies on the Committee only for a post-audit with a view to possible subsequent adjustment. The cost of this service to the National Health Insurance carriers is considerably below those assessed upon the members of the Social Insurance Medical Fee Payment Fund. (In that same prefecture the comparative rates quoted were ¥2 and ¥15 respectively per case, yet even that low sum had proved difficult of collection.)

B. Under Workmen's Accident Compensation Insurance

Compensation of Workmen's Accident Compensation Insurance claims is made entirely outside the Fund. In all cases of occupational accident or sickness, the injured worker must obtain from the employer a standard form (issued by the Labor Ministry) certifying the occupational origin. He takes this form to the doctor or hospital and the doctor notes on the same form his diagnosis and charges for treatment and sends it to the nearest Labor Standards Office for payment at the regular (not insurance) rates. (Bills below ~~¥300~~ 600 are paid directly by the employer.)

Incl A thru F

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Specification of Medical Treatment Bill
for the Month of ..... (Hospitalization)
(Ambulatory)

Kind of Insurance	Government Managed Society Managed	Primary insured Dependent

Number of the insurance card.		No.
Name of the insured, formerly insured person or dependents		Male Age Female
Name of sickness or injury		(1) (2)
Date of the first consultation and number of days of medical treatment		(1) Month Year (Days) (2) Month Year (Days)
First consultation fee and second consultation fee.		1st consultation points
Charge for doctor's home visit.		
Charge for medicine	Medicine for internal use Dose of medicine taken only once. Medicine for external application	Compounding of medicine Days Times Points Times Points
Charge for injection	Hypodermic and muscular. Intravenous injection Arterial injection	Times Points Times Points Times Points
Surgical operation		Name of operation Points
Treatment		Name of treatment Points
Others		Points
Hospital charge		With board Without board Days Points
Total number of points		No. of points required. No. of points certified after review.

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Number of the insurance card.		No.
Name of the insurer		
Name of the insured, formerly insured person or dependents		Male Age Female
Name of sickness or injury		(1) (2)
Date of the first consultation and number of days of medical treatment		(1) Month Year (Days) (2) Month Year (Days)
First consultation fee and second consultation fee.		1st consultation points
Charge for doctor's home visit.		
Charge for medicine	Medicine for internal use Dose of medicine taken only once. Medicine for external application	Compounding of medicine Days Points Times Points Times Points
Charge for injection	Hypodermic and muscular. Intravenous injection Arterial injection	Times Points Times Points Times Points
Surgical operation		Name of operation Points
Treatment		Name of treatment Points
Others		Points
Hospital charge		With board Without board Days Points
Total number of points		No. of points required. No. of points certified after review.
Result	Healed Carried over Death Date	Remarks

Name of the bank or post office designated for the receipt of the medical fee.
Name and address of the insurance doctor.

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Specification of Dental Treatment Bill
for the month of .....

Kind of insurance	Government managed H. Ins. Primary insured Society managed H. Ins. Dependent

Number of the insurance card.				No.	
Name of the insurer.					
Name of the insured, formerly insured person or dependent.				Age / Date of birth	Male / Female
Location and name of sickness or injury.					
Date of first consultation and number of days of medical treatment of the month.				(1) Month Year (No. of days) (2) Month Year (No. of days)	
Breakdown.	First consultation fee				Points.
	Charge for medicine.	Medicines for internal use	Compounding of medicine.	Days	Points.
		Dose of medicine taken only once.		Times	Points.
		Medicine for external use.		Times	Points
	Charge for injection.	Hypodermic, muscular.		Time	Points.
		Intravenous injection.		Time	Points.
	Charge for treatment.		Name of treatment.		Points.
	Charge for filling teeth	Amalgam		Tooth	Points.
		Cement		Tooth	Points.
	Charge for inlay			Tooth	Points.
	Charge for repair of teeth.	Artificial teeth.		Tooth	Points.
		Metal frame	Gold	No.	Points.
			Substitute metal	No.	Points.
		Crown for teeth	Gold	Tooth	Points.
			Silver	Tooth	Points.
		Porcelain tooth crown.		Tooth	Points.
		Others.			Points.
	Charge for operation.	Pulling of teeth.		Tooth	Points.
		Others.		Name of operation.	Points
Others.					
Total number of points				No. of points required.	No. of points certified after review.
Result	Healed or carried over.		Remark		
	Date				

Name of the bank or post office designated for the receipt of the medical fee.

Name and address of insurance dentist.

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Incl. C.

Investigation Paper for the Month of ----

Name of Insuranc

Name of Examiner ----

Breakdown		Medical fees (hospitalization) Amount requested this month. Cases	Days	Amount certified after review, Cases	Days	Points	Medical fee	Medical fees (an Amount requested this month. Cases	Days	Amount c Cases	Da
H. Ins. Gov't manged	Primary insured										
	Dependent										
Seamen's Ins.	Primary insured										
	Dependent										
Mutual Aid Association	Primary insured										
	Dependent										
Health Ins. Society	Primary insured										
	Dependent										
N.H.Ins. Association	Primary insured										
	Dependent										
Total	Primary insured										
	Dependent										

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Name of Insurance Doctor

...cal) fees (hospitalization)					Medical fees (ambulatory)					
...ted	Amount certified after review,				Amount requested this month.		Amount certified after review			
...ys	Cases	Days	Points	Medical fee	Cases	Days	Cases	Days	Points	Medical fee

Incl. E.

Notice of Payment on the Current Account Form 5.

Date

Social Insurance Medical Fee Payment Fund Office

-----Bank (Branch Office
(Agency

To: Name of insurance doctor.

We hereby notify you that the medical fees for the month of -----have been deposited in your account as specified below.

Breakdown	Number of cases	Number of points	Amount deposited
Health Insurance (Government Managed)			
Seamen's Insurance			
Mutual Aid Assn.			
H. Ins. Assn.			
N. H. Ins. Assn.			
Total			
Remark			

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Incl. F.

Specification of Payment of Medical Fee
For the Month of -----

To: ----- Bank

Social Insurance Medical Fee Payment
Fund Office.

Number of account	Name of account	Amount paid	No. of cases paid for	No. of points	Remarks

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Incl. D.

Specification of Medical Fees by Insurance Doctor
for the Month of ----

Fiscal year ----

Name of insurance doctor	Breakdown	Medical fee (hospitalization) Amount requested this month.		Amount certified after review.				Medic Amount re this mon
		Cases	Points	Cases	Days	Points	Medical fee	Cases
	Primary insured							
	Dependent							
	Primary insured							
	Dependent							
	Primary insured							
	Dependent							
	Primary insured							
	Dependent							
	Primary insured							
	Dependent							
	Primary insured							
	Dependent							
	Primary insured							
	Dependent							
	Primary insured							
	Dependent							

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Doctor

Incl. D.

Social Insurance Medical Fee
Payment Fund Office

review.	Medical fee (ambulatory) Amount requested this month.		Amount certified after review.				Total amount of medical fees paid.	Amount of admini expense charged.
edical fee	Cases	Points	Cases	Days	Points	Medical fee		

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nsurance Medical Fee
Fund Office

fee (ambulatory) Amount certified after review.		Total amount of medical fees paid.	Amount of administrative expense charged.
Cases	Days Points Medical fee		