Form No. 2

Certificate of Medical Costs for Consultation/Examination for Minato City Specified Fertility Treatments

I certify that the medical fees were related to the specified fertility treatments described below, carried out because the possibility for conception/pregnancy by the patient by any other means is nil or extremely poor.

Date: (YMD)

Name and location of medical facility

Name of primary physician providing treatment Seal

To be filled out by medical institution (primary physician)

Katakana	Patient		Spouse		
Patient name					
Date of birth		Date: YMD (Years)		Date: YMD (Years)	
Method of treatment	A B C D E F Male only (Circle letter for appropriate treatment)		For A or B 1. In vitro fertilization 2. Micro-insemination (Circle number for appropriate treatment)		
Period of treatment	Year Month Day – Year Month Day		(Date of confirmation of pregnancy or termination of		
	Date of ovum collection (A–F)		Positive:	Y M D	
	Embryo cryopreservation (freezing) (B–D)		Positive:	Y M D	
	Embryo transplantation (A–C)		Positive:	Y M D	
	Embryo could not be transplanted; treatment terminated (D)		Completion:	Y M D	
	Treatment terminated by physician for unavoidable reasons (E / F)		Date of decision to terminate treatment:	Y M D	
I received a prescription necessary for this fertility treatment to be filled at an outside pharmacy			Yes: Name of pharmacy		
A portion of this fertility treatment was carried out at a different medical facility			Yes: Name of medical facility		
Amount of payment received	The total amount for this specified fertility treatment not covered by medical insurance (Period of receipt Y M D ~ Y M D) Amount received JPY *Fees for documentation and amounts covered by insurance should not be included. If there is a Certificate of Surgery for Intratesticular Biopsy/Sperm Retrieval (Form No. 3), include the amount shown on that form and enter the total received on the line above.				
Only to be completed if there is a Certificate of Surgery for Intratesticular Biopsy/Sperm Retrieval (Form No. 3)	Name of medical facility carrying out procedure		*Enter the amount received from Form No. 5 Amount received		

Notes: treatment eligible for subsidy must meet the following conditions
A. A fresh embryo transplant must be carried out.
B. A complete cycle from ovum collection to transplantation of cryopreserved embryo was carried out (when adopting the method in which one series of treatments comprises ovum collection, ovum fertilization and cryopreservation; to preserve the physical condition of the mother, transplantation of the embryo was carried out after an interval of 1-3 cycles), including OHSS (ovarian hyperstimulation syndrome).
C. Transplantation of a previously frozen embryo was carried out.
D. Treatment was terminated due to poor health, etc. and a future date for transplantation could not be set.
E. Fertilization could not be carried out, or was terminated because the embryo stopped dividing, degenerated, was inseminated by multiple sperm or showed other sign of abnormal fertilization.
F. Treatment was terminated because ovum collection produced no ova or no viable ova.
Note: cases not leading to ovum collection (treatment without invasive procedures) are not eligible for subsidy. However, only cases where sperm retrieval surgery (not covered by medical insurance) was carried out, but treatment was terminated because no sperm were retrieved shall be eligible, even if ovum collection has not been carried out. In this case, surgery eligible for subsidy shall be limited to treatments terminated after April 1, 2016.

*This document is not required if also applying for the designated treatment in Tokyo, etc.