CLALLAM COUNTY DISABILITY BOARD
MEDICAL CLAIM REIMBURSEMENT FORM for LEOFF I RETIREMENT SYSTEM

SUBMIT COMPLETED FORM TO:
Clallam County Disability Board
223 E. 4TH St., Suite. 16
Port Angeles, WA 98362-3015

FROM WHAT AGENCY:

NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
DAYTIME PHONE:		

SOURCES OF REIMBURSEMENT:

☐ MEDICARE ☐ OTHER INSURANCE: _____ POLICY NUMBER: _____

SECTION A: **Doctors, Clinics, Hospitals, Labs, etc.**

DATES OF SERVICE	DESCRIPTION OF TREATMENT	PROVIDER	ORIGINAL AMOUNT BILLED	AMOUNT PAID BY INSURANCE/MEDICARE	PATIENT'S RESPONSIBILITY *AFTER* INSURANCE REIMBURSEMENT

TOTAL SECTION A: _____

Form updated 11/2009

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SECTION B: Prescriptions (*Receipts Must Be Included With Claim*)

DATE FILLED	PRESCRIPTION NUMBER	NAME OF PHARMACY	AMOUNT PAID BY INSURANCE/MEDICARE	PATIENT'S RESPONSIBILITY *AFTER* INSURANCE REIMBURSEMENT

TOTAL SECTION B: _____

(FROM FRONT OF FORM) **TOTAL SECTION A:** _____

TOTAL THIS CLAIM: _____

MY CLAIM IS FOR OUT-OF-POCKET EXPENSES *AFTER* INSURANCE OR MEDICARE PAYMENTS HAVE BEEN ISSUED. I UNDERSTAND THAT I MUST INCLUDE INSURANCE/MEDICARE EXPLANATION OF BENEFITS FORMS FOR PAYMENT VERIFICATION. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO SEE TO PAYMENT OF THE SERVICE PROVIDER(S) BEFORE CHARGES BECOME DELINQUENT. THIS CLAIM CONTAINS NO LATE CHARGES, INTEREST OR MISSED APPOINTMENTS.

I HEREBY ATTEST THAT, TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE AND CORRECT. I HEREBY AUTHORIZE ANY SERVICE PROVIDER WHO HAS TREATED ME FOR THIS CONDITION TO RELEASE MY MEDICAL RECORDS TO CLALLAM COUNTY DISABILITY RETIREMENT BOARD OR ITS DESIGNEE. FURTHERMORE, I HEREBY CONSENT TO EXAMINATION BY ANY OTHER PHYSICIAN(S) THE BOARD MAY REQUIRE. I UNDERSTAND THAT THIS CONSENT IS GIVEN ONLY FOR THE PURPOSE OF ESTABLISHING MY LEOFF-I BENEFITS.

SIGNED: _____ **DATE:** _____

LEOFF-I MEMBER

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