City of Bellevue LEOFF 1 Disability Board Medical Claim Form

LEOFF 1 Active/Retiree Information:

Name: _____ **Date of Birth:**_____

Address:_____ **SSN#: XXX-XX-** __ __ __ __

City:_____ **State:**_____ **ZIP Code:**_____

Telephone Number:_____

If claim is approved, check should be made payable and mailed to: _____

_____

Reimbursement Request Information:

Service Date	Provider	Service Received	Medical Reason	Uncovered Cost

Total: $_____

_____ _____

Claimants Signature **Date Submitted**

Submission to the Disability Board must include the following:

- Completed Disability Board Medical Claim Form.
- Itemized statement from the service provider indicating any insurance payments or other payments made to the provider.
- Insurance Carrier's "Explanation of Benefits" (EOB) form and Medicare Statement for any claim submitted by a member covered by Medicare.
- Provider Billing invoice if not covered by Insurance. Please provide explanation as to why this is a medical necessity (Medical Necessity is determined by the City of Bellevue Disability Board).

Submit this form with applicable receipts, statements and "Explanation of Benefits" (EOB) to:

City of Bellevue LEOFF 1 Disability Board
Human Resources
PO BOX 90012
Bellevue WA 98009-9012
Phone: 425-452-7198