LEOFF 1
City of Bellevue
Disability Board Medical Claim Pre-approval Form

To be completed by LEOFF 1 member's physician to establish medical necessity for procedures or services not covered under member's medical plan.

Member Name ____
(please print)

1. Diagnosis: ____
2. Prognosis: ____
3. Type of Treatment(s) or Procedure: ____________________________
4. Reason for this specific treatment or procedure: ________________

   ____

   ____

5. Length and/or number of treatments:____________________________
6. Expected outcome: _______________________________________
7. Estimated cost of treatments/service: $ _________________________

____
Physician's Signature
(Please attach business card)

Return to:
City of Bellevue
Disability Board
PO Box 90012
Bellevue, WA 98009

FAX: (425) 452-4071