

**City of Des Moines
LEOFF I MEMBER CLAIM FORM
Reimbursement of Medical/Dental*/Vision Expenses**

Name: _____ Date of Birth: _____
 Street Address: _____ Telephone: _____
 City: _____ State: _____ ZIP: _____

OTHER SOURCES OF REIMBURSEMENT

Insurance/Medicare: _____ Policy No.: _____

MEDICAL CONDITION(S): _____

EXPENSES INCURRED

Date of Service	Description of Procedure	Provider Name	LEOFF I Responsibility

Total Claim (minus insurance/Medicare responsibility)--\$

I have attached copies of billing statements, and other supporting documents. _____ (initial)

The condition treated was not due to by licentiousness or abuse, and the expenses were solely for necessary medical/dental*/vision service. _____ (initial)

It is my responsibility to pay for services before charges become delinquent. _____ (initial)

This claim contains no late charges, interest or missed appointments. _____ (initial)

*Dental bills are paid under the following condition of RCW 41.26.030 (22) (H) "...incurred by a member who sustains an accidental injury to his or her teeth and who commences treatment by a legally licensed dentist within ninety days after the accident..."

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 the City of Des Moines LEOFF I Disability Board, or its designee. Furthermore, I hereby consent to examination by any other physician the Board may require. I understand that this consent is only for establishing my right to LEOFF I benefits.

Signed: _____ Date: _____

LEOFF I Member