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

Name: Dale Southwick **Date of Birth:** 06/19/1961
Street Address: 4617 W Tapps Dr E **Telephone:** 253-862-1183
City: Lake Tapps **State:** WA **ZIP:** 98391

OTHER SOURCES OF REIMBURSEMENT
Insurance/Medicare: Medicare **Policy No.:** 72-8925

MEDICAL CONDITION(S): Everything is wrong

EXPENSES INCURRED

Date of Service	Description of Procedure	Provider Name	LEOFF I Responsibility
11/10/10	Test	VM	100.00
11/11/10	Test	VM	50.00
12/02/10	Test	VM	200.00
12/15/10	Test	VM	500.00
12/22/10	Test	VM	700.00
12/25/10	Test	VM	1,000.00
Total Claim (minus insurance/Medicare responsibility)--$			**2,550.00**

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