## **CITY OF REDMOND**

## **DISABILITY BOARD CLAIM**

## LAW ENFORCEMENT OFFICERS AND FIRE FIGHTERS (LEOFF I)

This form is to be used ONLY for submitting claims through the Disability Board and is not to be used for claims submitted through your health insurance carrier.

Name:		Date Submitted:
Addre	ss:	
A.	Gene	eral Information
	1.	Have you submitted this claim through your insurance carrier? Yes No
	2.	If yes, has part or all of the claim been denied? (Please attach denial of claim)  Partial All
	3.	Explain the services received
B.	<u>If you</u>	ur claim is for an eye examination, eyeglasses, or contacts:
	1.	Have you been examined within the last year and been reimbursed by the Disability Board for such services?  Yes No
	2.	If yes, have you attached a doctor's statement stating that your prescription has changed? Yes No
C.	Grou	p Health Only:
	1.	Explain reasons you did not use Group Health facilities
	2.	Prescriptions for Medicare: has maximum been submitted? Yes No
D.	An it	temized statement is required. Please attach.
E.	If yo	ur claim is approved, the check should be made payable to:

This form, plus an Explanation of Benefits, an itemized statement, and a Claim for Expense form should be submitted to the Human Resources Department 10 days prior to a Disability Board meeting  $(1^{st}$  Wednesday of each month).