LEOFF 1 CLAIM FOR PAYMENT FORM

SEND CLAIMS TO:
City of Auburn HR Dept.
Attn: LEOFF Board Secretary
25 W Main St, Auburn, WA 98001

PART 1: RETIREE (CLAIMANT) INFORMATION-- FIRE ❑ POLICE ❑

_____ _____
Name (Last, First) Phone Number

_____ _____ _____
Street Address City State, Zip Code

Is this a change of address? Yes ❑ No ❑ Email: _____

PART 2: DESCRIPTION OF BILL-- MEDICAL ❑ PRESCRIPTION ❑ DENTAL ❑ VISION ❑

**Use additional page if needed*

_____ _____
Description of Service(s) Received Date(s) of Service

Total Bill: $_____ Amount submitted to LEOFF Board: $_____

***NOTE: All required back-up documentation must be provided/included with this claim form.**

Insurance EOB attached? Yes ❑ No ❑ Payment receipt attached? Yes ❑ No ❑

Is this for a work-related injury or illness? Yes ❑ No ❑ Related to an accident? Yes ❑ No ❑

Are you covered by any other insurance (other than Medicare and the City's insurance)? Yes ❑ No ❑

Other Insurance information (name of Insurance, Group #, address, etc.): _____
_____

PART 3: CERTIFICATION (for all claims)

I certify that the above information is complete and accurate to the best of my knowledge. I expressly authorize any service provider who has treated me to furnish my medical records to the City of Auburn LEOFF Board or its designee. I consent to examination by any other medical professional that the Board may require. I understand that this consent is given only for the purpose of establishing my right to LEOFF 1 benefits.

_____ _____
RETIREE (CLAIMANT) SIGNATURE DATE

----------The following section to be completed by LEOFF Board Secretary----------

APPROVAL OF CLAIM ❑ **DENIAL OF CLAIM ❑** **See back page for reason*

I certify that the LEOFF Board has reviewed the request and made the above recommendation based on the documentation provided.

_____ _____
LEOFF Board Representative (Designee) Signature DATE

REASON FOR DENIAL OF CLAIM:

_____

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