FRANKLIN COUNTY LEOFF I DISABILITY BOARD
APPLICATION FOR MEDICAL BENEFITS NOT INCLUDED UNDER ANY INSURANCE COVERAGE

The undersigned employee/retiree hereby makes application to the Franklin County LEOFF I Disability Board for payment of medical services provided to the applicant. The services enumerated below are not payable under any other available coverage and are covered by Washington State Laws.

NOTE: All LEOFF I Plan members are ultimately responsible for hospital and medical accounts, and for any late charges added as a result of overdue payments.

Name of Applicant: Age:

Address:

Home Telephone: Employer: Retired From:

Name of Applicant's Health Care Provider (doctor, hospital, etc.):

Address of Provider: Telephone:

Insurance Coverage: Group No. Policy No.

Describe the injury or illness for which this application is being filed and give a brief history of said injury or disease (use a second sheet if necessary):

Date(s) of Treatment:

Attach all bills for treatment received relative to this claim. The bills must be itemized, showing the treatment provided, the type of drug(s) prescribed, etc. "Balance forward" statements are not acceptable. Attach original insurance company's Explanation of Benefits form and any other documentation on amount(s) paid.

Less Provider Discount $_____
Amount(s) paid from insurance or Medicare: $_____
Amount(s) not covered by any other insurance or Medicare: $_____

Amount(s) paid by Applicant: $_____
Amount owed to Provider: $_____

I certify that the information and charges here shown are true and correct, that all available insurance coverage has been utilized, that these services and/or medications were received by me, and that I am liable for these charges. I hereby authorize all doctors, pharmacists, hospitals, or other institutions rendering care and treatment to furnish the Franklin County Disability Board with full information regarding treatments rendered.

_____ _____
Signature of Applicant Date

Submit completed Application, with all required supporting documents, to the Franklin County Disability Board, Courthouse, 1016 N. 4th Ave., Pasco, WA 99301, **retaining the pink copy for your records.** Applications must be submitted **at least 12 days prior to the Board's next regular meeting** (see current Board Rules & Regulations, pg. 1, for meeting day).

Fiscal Office: FCSO Date Claim Reviewed by Board: _____
Application Reviewed By: ____ Moved Payment in Amt. of $_____ Denied: _____
_____ Reason, if Denied: _____
Chairman