

WHITMAN COUNTY LEOFF I BOARD
400 N Main Street, Colfax, WA 99111
(509) 397-5246
FAX (509) 397-6355
MEDICAL EXPENSE CLAIM FORM

REVISED
COMPLETION OF ENTIRE FORM REQUIRED

LEOFF I MEMBER'S NAME: _____

MAILING ADDRESS: _____
Street City State Zip Code

DAYTIME OR MESSAGE TELEPHONE NUMBER: (____) _____

Please provide the following information about this claim:

Date of Service		
Medical Care Provider		
List Service(s) Provided (Attach additional sheet if necessary)		
Diagnosis (Attach additional sheet if necessary)		
Submitted to Medicare?		____ Yes or ____ No
If not submitted to Medicare, why not?		
Total Charges		\$
Less Amount Medicare Part A & B Paid		\$
Less Amount Medicare Part D Paid		\$
Less Amount Other Insurance(s) Paid		\$
Amount to be Paid by LEOFF I Board		\$
Who Should Check Be Made Payable To?		

Please attach a copy of the invoice and explanation of benefits showing payment from other sources. If your claim was rejected, attach a copy of the rejection notice.

I certify that these statements are correct and that the services were provided as indicated. I authorize any Provider, Plan Administrator, or Third Party Administrator to disclose any information regarding my benefit coverage that is necessary to process this claim. I attest that the injury/illness, which prompted this claim, was not a result of criminal conduct by the Member, dissipation or abuse. I authorize payment of any LEOFF I medical benefits to the physician or supplier of medical services listed on the attached invoice.*

Member's Signature

Date

This completed form and all supporting documentation (invoices, insurance rejections, statement of benefits) should be submitted TO YOUR EMPLOYER (OR FORMER EMPLOYER IN THE CASE OF RETIREES) FOR PAYMENT. Your employer or former employer may submit this claim to the **LEOFF I BOARD FOR REVIEW**. If you have any questions regarding the claims process, please contact your employer or the Clerk of the Whitman County LEOFF I BOARD at (509) 397-6202.