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

DATE: _____

TO: LEOFF I RETIREE, _____

FROM: LEOFF I BOARD

RE: _____ PRESCRIPTION REIMBURSEMENT
_____MEDICAL REIMBURSEMENT
_____ PAYMENT OF MEDICAL SERVICES
_____ REQUEST FOR MEDICAL SERVICES
_____ REQUEST FOR MEDICAL EQUIPMENT
_____ MEDICARE PREMIUM
_____OTHER

Dear Retiree:

The Whitman County LEOFF I Board have considered your request for payment

Your request has been:

_____Approved

_____ Pending

_____Rejected based on _____

_____

_____

This action was taken by the Board on _____.

In accordance with Whitman County LEOFF I BOARD policy you have 30 days from the denial of the claim/request by the Board to appeal their decision. The Board will set a date and time for reconsideration at which time you may present such evidence deemed relevant. If the Board sustains denial of the claim/request, you have the right of judicial review.

_____
Secretary or Clerk of the LEOFF I Board