CLAIM FORM

SEATTLE FIREFIGHTER'S PENSION BOARD
2200 6TH AVE # 820, SEATTLE, WA 98121-1822
206-625-4355 1-800-993-3473 FAX 206-625-4521

PENSION WEBSITE – WWW.CITYOFSEATTLE.NET/FIREPENSION

FORM REQUIREMENTS

- WHEN YOU RECEIVE MEDICAL CARE FOR A NEW, EXISTING, OR ONGOING CONDITION THAT YOU HAVE BEEN RECEIVING CARE FOR IN EXCESS OF ONE YEAR, PLEASE FILL OUT THIS FORM AND SEND IT TO OUR OFFICE.

  EXAMPLE: IF YOU HAVE SEEN A PHYSICIAN FOR A BROKEN LEG AND HAVE SUBMITTED A CLAIM FORM FOR THAT INJURY THEN ANOTHER FORM IS NOT REQUIRED FOR FOLLOW UP VISITS FOR THE LEG INJURY. IF YOU THEN BREAK YOUR ARM AND SEE THE SAME PHYSICIAN FOR THE ARM INJURY SEND US A NEW CLAIM FORM FOR THAT INJURY. THE CLAIM FORM IS VALID FOR ONE YEAR FOR EACH INJURY OR ILLNESS. CLAIM FORMS ARE NOT REQUIRED TO BE SIGNED BY A PHYSICIAN.

- FOR SITUATIONS SUCH AS QUARTERLY LAB WORK ETC SEND US A FORM ANNUALLY.

- FOR PERSCRIPTION CO-PAY REIMBURSEMENTS OR OVER THE COUNTER ITEMS PLEASE COMPLETE THIS FORM. PERSCRIPTIONS ARE REQUIRED FOR OVER THE COUNTER ITEMS AND MUST BE RENEWED ANNUALLY.

CLAIM FORM

TO PROCESS BILLS IN A TIMELY MANNER ALL QUESTIONS MUST BE ANSWERED
Name Phone ( )
Address City State Zip
INDICATE THE USE OF THIS FORM:
Medical Services____ Reimbursement____ (Reimbursements Require Prescription Form, Receipt and Claim Form)

Date of Medical Service______________ Name of Physician or Specialist____

If you have seen this provider in the past and have a Referral on file check here ________

Nature of Injury or Illness or Medical Service: (Be as detailed as possible)

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INSURANCE COVERAGE: Do you have any other medical coverage? Yes ____ No ____ If yes, indicate all that apply:

Medicare _____ Group Health _____ Other (Specify) ____

Member Signature ____ Date Signed _________________________