# REFERRAL FORM FOR ACTIVE MEMBERS

## SEATTLE FIREFIGHTER'S PENSION BOARD

2200 6TH Ave – Ste 820 – Seattle, WA 98121-1822
(206) 625-4355 – 1-800-993-3473 – Fax (206) 625-4521
www.cityofseattle.net/firepension

**ACTIVE REFERRAL FORM**
**ALL QUESTIONS MUST BE ANSWERED**

Name ______________________________ Phone (_____ ) ______________ Assignment _______ Dept. ID# _____

Address ____________________________ City ___________________ State____________ Zip _________-___

**ALL MEMBER'S MUST COMPLETE**

Date of Medical Service_____________ Name of Physician or Specialist______________________________

Nature of Injury or Illness or Medical Service ____________________________________________

____________________________________________________________

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

Medicare _____ Regence _____Group Health _____ Other (Specify)

_______________________________

Member Signature ___________________________________ Date Signed___________________

**Cause and Place of Injury or Illness:**

____________________________________________________________

**Witnesses:**__________________________________________________

**Was this in the line of duty? Yes___ No ___ Recurrence? Yes ___ No ___**

**Date and time of layoff ______________________ Application for disability ______ Precautionary _____**

**PRIMARY CARE OR PENSION BOARD PHYSICIAN'S MEDICAL REPORT**

Is this in the line of duty Disability Yes____ No ____ Estimated length of Disability ____________________

Diagnosis:_____________________________________________________

____________________________________________________________

Referred For: Surgery ___Labs ___ Physical Therapy ____ Medical Appliance(specify)________________

MRI X-Rays ____ Other ______________________________________________

Primary Care or Pension Physician's Signature_______________________________ Date ___________

A REFERRAL FORM IS NOT AN AUTHORIZATION FOR PAYMENT OF SERVICES NOT COVERED BY BOARD POLICY

**REFERRAL AUTHORIZATION**

To: ____________________________________________ Phone: ( ) ______________

To: ____________________________________________ Phone: ( ) ______________

To: ____________________________________________ Phone: ( ) ______________

To: ____________________________________________ Phone: ( ) ______________

For: Eyecare ____ Chiropractor ____ Other (specify) ___________________________________

Physician's Signature _________________________________ Date: __________________

**PENSION BOARD OFFICE USE ONLY**

**Date of return ________ Time ________ Days Lost __________________ Approved ________________**

THIS FORM IS REQUIRED WHENEVER SEEING A NEW PROVIDER AND MUST BE SENT TO PENSION OFFICE