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
INFORMATION LINE 1-855-558-7565
PENSION WEBSITE – WWW.CITYOFSEATTLE.NET/FIREPENSION

WHENEVER YOU RECEIVE MEDICAL CARE FOR A NEW CONDITION OR FOR AN 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. FOR SITUATIONS SUCH AS QUARTERLY LAB WORK ETC SEND US A FORM AT LEAST ANNUALLY. YOU NO LONGER NEED TO RENEW REFERRALS EVERY YEAR. IF YOU HAVE SEEN THIS PHYSICIAN IN THE PAST AND HAVE SENT US A REFERRAL FORM INDICATE SO BY PLACING A CHECK IN THE BOX ON THIS FORM.

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.

THIS IS ALSO THE FORM THAT YOU WOULD USE FOR REIMBURSEMENTS FOR PRESCRIPTION CO-PAYS OR OVER THE COUNTER ITEMS. PRESCRIPTIONS 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, Itemized Bill with 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 _____

Revised 1-2015