

CLALLAM COUNTY DISABILITY BOARD

MEDICAL CLAIM REIMBURSEMENT FORM for LEOFF I RETIREMENT SYSTEM

SUBMIT COMPLETED FORM TO:
Clallam County Disability Board
223 E. 4TH St., Suite. 16
Port Angeles, WA 98362-3015

FROM WHAT AGENCY:

NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
DAYTIME PHONE:		

SOURCES OF REIMBURSEMENT:

MEDICARE OTHER INSURANCE: _____ POLICY NUMBER: _____

SECTION A: Doctors, Clinics, Hospitals, Labs, etc.

DATES OF SERVICE	DESCRIPTION OF TREATMENT	PROVIDER	ORIGINAL AMOUNT BILLED	AMOUNT PAID BY INSURANCE/MEDICARE	PATIENT'S RESPONSIBILITY <i>AFTER</i> INSURANCE REIMBURSEMENT

TOTAL SECTION A: _____

