LEOFF Board Application for Payment of Services

Case No: ____________

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: ________________________________ Active: ________ Retired: _________

Member Telephone: _____________________________ Police: ________ Fire: ___________

Member Address: ____

Alternate Contact: __________________________ Alternate Contact Telephone: _____________

Describe Your Condition and Why It Is Duty Related: ____________________________________

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Describe the Service/Treatment Requested: ____

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Total Cost of Treatment/Service: $ ____________

Amount Paid by Insurance/Medicare: $ ____________

Amount Requested from the Board $ ____________

Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the amount paid for this treatment/service.

Member Signature: ______________________________________ Date: _________________

Please attach a copy of the Power of Attorney if signed by the alternate contact.

B) This Section To Be Completed by Member's Attending Health Care Provider

(attach additional pages as needed)

Provider's Name: ______________________________ Provider's Telephone: _________________

Clinic/Office Name: ____

Provider's Address: ____

Describe the Patient's Current Condition and State Whether It Is Duty Related: __________________

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Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: ________________

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Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:

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Provider's Signature: ____________________________________ Date: ___________________

Fax Completed Form to: (360) 709-2735 or mail to: City Of Olympia HR Dept, PO Box 1967, Olympia WA 98507-1967