LEOFF 1
Claims Reimbursement Form (Fire)

Name (Last, first)		*Vendor #		Date claim submitted	
		*Bars #	014-1714-530-22.02		
Address		Primary phone #		Check if new (address, phone or email)	☐
City, State Zip		Cell #			
Email		*HR internal use			

PLEASE COMPLETE AND SUBMIT THIS FORM WITH ALL CLAIM REIMBURSEMENTS

Date of Service (in date order oldest to newest)	Enter either (prescription, Medical, Dental or Vision)	Description	Qty	Total
		Total		

Submit claims for reimbursement via:

- Mail: Attn: HR, City of Olympia, 601 4th Ave. E., Olympia, WA 98501
- Email: humanresources@ci.olympia.wa.us
- Fax: 360-709-2735

LEOFF 1 Disability policies and procedures, forms and detailed information about how to submit claims are posted on the city's website: LEOFF Disability Board Information

How to Submit LEOFF claims for reimbursement

1. Reimbursement claims must be submitted **within one calendar year** from date of service.

2. All claims for medical reimbursements **must** include the following:
   - Claims reimbursement form
   - Provider's statement (statement from health care provider)
   - Proof of payment (receipt)
   - Explanation of benefits (EOB) from Medicare Advantage, and/or Regence/Kaiser. If you are covered by more than one insurance, an EOB from **both providers** will need to be submitted.

   There is no need to submit EOB'S that show $0 or no patient responsibility.

3. Please tape prescriptions in date order on a letter sized piece of paper. Do not include the pharmacy drug interaction (patient advisory) section.

4. Claims for long term care, hearing aids, and claims that are not covered by insurance, must be deemed medically necessary by member's attending health care provider. Members are required to seek pre-approval by submitting An Application for Payment of Services that will go before the LEOFF Disability Board for consideration **PRIOR** to any medical/dental procedure being done.

5. **Dental claims** that exceed the annual allowable amount of $600 (which includes $50.00/mo. dental plan premiums) **must** be deemed medically necessary by member's attending health care provider. Members are required to seek pre-approval by submitting An Application for Payment of Services that will go before the LEOFF Disability Board for consideration **PRIOR** to any medical/dental procedure being done.

6. **Vision Claims**- Refer to the LEOFF policies and procedures, for allowable expenses. MedAdvantage members are covered under Vision Services Plan (VSP) and must **first** submit their vision claim form (form online) to insurance for the hardware benefit. Group Health members will receive $150 hardware benefit and MedAdvantage (Regence) receive $200 hardware benefit.

7. **Hearing Aids**-Must submit to the board prior to purchase: 1) Physician prescription/referral, 2) current hearing test/exam, 3) two quotes from licensed audiologists. One of the quotes must be from Costco if member lives within 25 miles. If LEOFF member is not a Costco member, the board will reimburse the LEOFF member for the membership fee. Hearing aids must have a three (3) year warranty. Reimbursements will be made for batteries and ordinary/necessary repair not due to carelessness.

8. For change of address, phone or email, please check the box located on the upper right hand corner of the Claims Reimbursement form or complete the Member Update form online, or contact the Human Resources Dept. as soon as possible. Otherwise, reimbursements and retirement checks may take longer to receive from our Accounting department.

We hope that this summary helps simplify the reimbursement process. Thank you in advance for following these procedures. If there are any questions or concerns, please contact Debbi Hufana at (360) 753-8149 or dhufana@ci.olympia.wa.us.