

# CLAIM FORM

SEATTLE FIREFIGHTER'S PENSION BOARD  
2200 6<sup>TH</sup> AVE # 820, SEATTLE, WA 98121-1822  
206-625-4355 1-800-993-3473 FAX 206-625-4521

PENSION WEBSITE – [WWW.CITYOFSEATTLE.NET/FIREPENSION](http://WWW.CITYOFSEATTLE.NET/FIREPENSION)

## FORM REQUIREMENTS

- WHEN YOU RECEIVE MEDICAL CARE FOR A NEW, EXISTING, OR 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.

**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.

- FOR SITUATIONS SUCH AS QUARTERLY LAB WORK ETC SEND US A FORM ANNUALLY.
- FOR PERSCRIPTION CO-PAY REIMBURSEMENTS OR OVER THE COUNTER ITEMS PLEASE COMPLETE THIS FORM. 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
<b>INDICATE THE USE OF THIS FORM:</b>			
Medical Services _____	Reimbursement _____	(Reimbursements Require Prescription Form, 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 _____			
<b>Nature of Injury or Illness or Medical Service:</b> (Be as detailed as possible)			
_____			
_____			
_____			
<b>INSURANCE COVERAGE:</b> Do you have any other medical coverage? Yes _____ No _____ If yes, indicate all that apply:			
Medicare _____ Group Health _____ Other (Specify) _____			
Member Signature _____		Date Signed _____	