CITY OF RICHLAND LEOFF I FIRE
CLAIM FORM

PROVIDER PAYABLE TO:			
Pensioner Name		Primary phone #	
Address		Cell #	
City, State, Zip		Check if any changes to address/phone/email	
Email			

Internal Use Only			
Vendor #		*Account Coding*	

PLEASE COMPLETE AND SUBMIT THIS FORM WITH CLAIM

Date of Service	Type of Service (Medical, Dental, Vision or RX)	Description of Service	Post Insurance for Board Consideration

Check all boxes below that apply to you.

	I have attached copies of billing statements, Explanation of Benefits(Medicare/City of Richland Healthcare Benefits Plan Administrator, other), receipt and other supporting documents.
	I understand that it is my responsibility to submit claims in a timely manner before charges become delinquent. This claim contains no late charges, interest or missed appointments.
	The services are in accordance with RCW 41.26.150.

Signature : _____ Date : _____

Submit claims for payment:

Mail or Deliver to: Firefighters' Pension Board, 625 Swift Blvd., Richland, WA 99352 - Attn: Finance Dept.