

**SEATTLE FIREFIGHTER'S PENSION BOARD**

2200 6<sup>TH</sup> Ave – Ste 820 – Seattle, WA 98121-1822  
(206) 625-4355 – 1-800-993-3473 – Fax (206) 625-4521

CHECK ONE  
**ACTIVE** \_\_\_\_\_  
**RETIRED** \_\_\_\_\_

**CLAIM/REFERRAL FORM**  
**ALL QUESTIONS MUST BE ANSWERED**

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_

**INDICATE THE USE OF THIS FORM:**

Medical Services \_\_\_\_\_ Referral \_\_\_\_\_ Reimbursement \_\_\_\_\_ (Requires Prescription Form, Receipt and Claim Form)

**ALL MEMBER'S MUST COMPLETE**

Date of Medical Service \_\_\_\_\_ Name of Physician or Specialist \_\_\_\_\_

Nature of Injury or Illness or Medical Service \_\_\_\_\_

**INSURANCE COVERAGE**

Do you have any other medical coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, indicate all that apply:

Medicare \_\_\_\_\_ Regence \_\_\_\_\_ Group Health \_\_\_\_\_ Other (Specify) \_\_\_\_\_

Member Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**ONLY ACTIVE MEMBER'S MUST COMPLETE THIS SECTION**

Cause and Place of Injury or Illness: \_\_\_\_\_

Assignment \_\_\_\_\_ Dept I.D. \_\_\_\_\_

Witnesses: \_\_\_\_\_

Was this in the line of duty? Yes \_\_\_\_\_ No \_\_\_\_\_ Recurrence? Yes \_\_\_\_\_ No \_\_\_\_\_

Date and time of layoff \_\_\_\_\_ Application for Disability \_\_\_\_\_ Precautionary \_\_\_\_\_

**IT IS THE MEMBER'S RESPONSIBILITY TO SUBMIT WHITE COPY OF CLAIM FORM TO THE PENSION OFFICE. LEOFF MEMBER'S, BX CARDS MUST BE PRESENTED TO PHYSICIAN, HOSPITAL, OR PHARMACY AT TIME OF SERVICE**

**PRIMARY CARE OR PENSION BOARD PHYSICIAN'S MEDICAL REPORT**

Is this a line of duty Disability Yes \_\_\_\_\_ No \_\_\_\_\_ Estimated length of Disability \_\_\_\_\_

Diagnosis \_\_\_\_\_

Referred For: Surgery \_\_\_\_\_ Labs \_\_\_\_\_ Physical Therapy \_\_\_\_\_ Medical Appliance (specify) \_\_\_\_\_

MRI \_\_\_\_\_ X-Rays \_\_\_\_\_ Other \_\_\_\_\_

Primary Care or Pension Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**A CLAIM/REFERRAL FORM IS NOT AN AUTHORIZATION FOR PAYMENT OF SERVICES NOT COVERED BY BOARD POLICY**

**REFERRAL AUTHORIZATION**

To: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

To: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

To: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

To: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

For: Eyecare \_\_\_\_\_ Chiropractor \_\_\_\_\_ Other (specify) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**PENSION BOARD OFFICE USE ONLY**

Date of return \_\_\_\_\_ Time \_\_\_\_\_ Days Lost \_\_\_\_\_ Approved \_\_\_\_\_

Distribution: White-Pension Office

Yellow-Member

Pink-Physician's/Chart