

CLAIM FORM

SEATTLE FIREFIGHTER’S PENSION BOARD

2200 6TH AVE # 820

SEATTLE, WA 98121-1822

206-625-4355 1-800-993-3473 FAX 206-625-4521

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

WHENEVER YOU RECEIVE MEDICAL CARE FOR A NEW CONDITION OR FOR A 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. THE MORE INFORMATION YOU CAN PROVIDE ON A CLAIM FORM THE EASIER IT IS FOR US AND BLUE CROSS TO PROCESS THE BILL.

THIS IS ALSO THE FORM THAT YOU WOULD USE FOR REIMBURSEMENTS FOR PRESCRIPTION CO-PAYS OR OVER THE COUNTER ITEMS PRESCRIBED BY YOUR PHYSICIAN.

CLAIM FORM

ALL QUESTIONS MUST BE ANSWERED	
Name _____	Phone () _____
Address _____ City _____ State _____ Zip _____ -	
INDICATE THE USE OF THIS FORM:	
Medical Services _____	Reimbursement _____ (Reimbursements Require Prescription Form, Receipt and Claim Form)

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 ___ Group Health ___ Other (Specify) _____

Member Signature _____ **Date Signed** _____