



City of Kent

Disability Retirement Board
 acaraballo@kentwa.gov
 Phone: 253-856-5279
 Fax: 253-856-6270
 Location: 400 W. Gowe Street, 4th Floor
 Mail to: **Amy Caraballo, Benefits Analyst**
LEOFF I Secretary
220 Fourth Avenue South
Kent, WA 98032

LEOFF I Claim for Medical Expenses

Name: _____ Telephone No. _____
 Address: _____ Date of Birth: _____
 City/State/Zip: _____ Date of Hire: _____

DEPARTMENT: FIRE _____ POLICE _____ (check one)

a. This is to certify that I have incurred medical expenses on _____ in the amount of \$_____, as follows: **(Attach original Blue Cross Explanation form and original prescription slips from pharmacy and Medco Health. Medicare forms may be copied.)**

b. Has any portion of the amount claimed been paid by another source?
 YES _____ NO _____ AMOUNT PAID \$ _____

c. Could any portion of the amount claimed be paid by another source?
 YES _____ NO _____ AMOUNT THAT COULD BE PAID \$ _____
 (If "YES", explain) _____

d. These expenses are solely for necessary medical services as directed by my physician:
(please print)
 DOCTOR: _____
 ADDRESS GIVEN: _____
 TELEPHONE GIVEN: _____

e. The injury or condition causing the expenses is as follows:

f. To the best of my knowledge, the above information is true and correct. I hereby authorize my physician who has treated me for this condition to release my medical records to the City of Kent Disability Retirement Board.

Signature: _____ Date: _____