

## CITY OF MOUNT VERNON LEOFF1 DISABILITY BOARD MEDICAL CLAIM REIMBURSEMENT FORM

**SUBMIT COMPLETED FORM TO**  
**City of Mount Vernon**  
**910 Cleveland Avenue, Attn HR**  
**Mount Vernon, WA 98273**

I AM:	ACTIVE	RETIRED
FROM WHAT AGENCY:	FIRE	POLICE

NAME:	DATE OF BIRTH:
ADDRESS:	
CITY, STATE :	ZIP:
HOME PHONE:	CELL PHONE:

**SOURCES OF REIMBURSEMENT:**

<input type="checkbox"/> MEDICARE    OR <input type="checkbox"/> Primary Insurance: _____	<input type="checkbox"/> Secondary Insurance: _____
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**SECTION A: Doctors, Clinics, Hospitals, Labs, etc. (include EOB and/or statement showing insurance pymts and adjustments)**

DATES OF SERVICE	DESCRIPTION OF TREATMENT	PROVIDER	ORIGINAL AMOUNT BILLED	AMOUNT PAID BY MEDICARE/ INSURANCE(S)	PATIENT'S RESPONSIBILITY AFTER INSURANCE REIMBURSEMENT

**TOTAL SECTION A:** \_\_\_\_\_

