CITY OF RICHLAND
POLICE PENSION CLAIM FORM

Payable To:

Pensioner Name:

Address:	**City, State, Zip:**
Home Phone:	**Cell Phone:**

Email:

To keep the City's records current, please circle any information that needs updating

PENSIONER MUST COMPLETE THIS SECTION AND ATTACH SUPPORTING DOCUMENTS

DATE OF SERVICE	TYPE OF SERVICE Medical / Dental / Vision RX / Medicare Payment	DESCRIPTION OF SERVICE	AMOUNT REQUESTED FOR BOARD APPROVAL

SUBMIT CLAIMS FOR PAYMENT VIA:

Hand Delivery: Police Pension at Richland City Hall, 625 Swift Blvd. Richland, WA 99352

Mail: Police Pension Board Secretary, 625 Swift Blvd. MS-05, Richland, WA 99352

Fax: 509-942-7379

By signing this form, I declare that I have read and understand the following statements, and I have attached the required documentation.

I have attached copies of the healthcare provider's itemized billing statement; Explanation of Benefits (EOB) statements from Medicare / Cigna / other insurance; receipts; prescription information; other supporting documentation.

I understand that I am responsible for submitting claims in a timely manner before charges become delinquent. This claim contains no late charges, interest or missed appointment charges.

Claims must be submitted within six (6) months from date of service to be valid.

The services are in accordance with RCW 41.26.150.

SIGNATURE:	**DATE:**

FOR INTERNAL USE ONLY	
Vendor Number:	Account Code: