CITY OF RICHLAND
LEOFF I FIRE 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**	**AMOUNT REQUESTED FOR BOARD APPROVAL**

SUBMIT CLAIMS FOR PAYMENT VIA:

Mail: Smith Consulting/Kristi Smith
PO Box 6800
Kennewick, WA 99336
Attn: Kristi Smith

Email: admin@smithconsulting.info **Fax:** 509-737-1494 **Phone:** 509-547-1277

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.

To the best of my knowledge, the services are in accordance with provisions of RCW 41.26.

SIGNATURE:	**DATE:**

FOR INTERNAL USE ONLY

Vendor Number:	Account Code:

Revised 12/2022