

# MEDICAL CLAIM FORM

## KCDRB Form 7

### LEOFF-I Physician/Health Care Provider's Statement

(To be completed by physician or primary health care provider)

Please mail this form to the patient's employer at the address provided below. If you have questions, call the King County Disability Retirement Board at 206-263-6394, or 206-684-1556 (call center).

Patient's name: \_\_\_\_\_ Insurance/HMO: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance billed?  Yes  No

Street Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Health care provider: \_\_\_\_\_

Street Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

#### Diagnosis

I have examined and treated the above-named LEOFF-1 member/claimant for the following medical condition(s):

\_\_\_\_\_  
\_\_\_\_\_

#### Etiology

The cause of the condition is: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

#### Treatment

I have prescribed or performed the following treatment on the dates indicated. (**Note:** For mental health, chiropractic and substance abuse treatment exceeding one month, a treatment plan *must* be submitted. Attach KCDRB Form 8, Physician/Health Care Provider Treatment Plan.)

\_\_\_\_\_  
\_\_\_\_\_

In addition, I have attached a medical report/evaluation.

#### Fee for Services

(Invoice/statement may be attached.)

\_\_\_\_\_

The services rendered by me and the medication, appliances or other therapies that I prescribed were necessary medical services in view of the patient's diagnosis and condition.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Physician/health care provider

**The King County Disability Retirement Board for LEOFF-1 will only accept original signed and dated claim forms. If you are concerned about privacy, do not e-mail personal information or a copy of this completed form to the Board - your privacy over the Internet cannot be guaranteed.**