L.E.O.F.F. CERTIFICATION FORM

Directions: Fill in all blanks, if applicable, and check all appropriate boxes. When submitting bill to LEOFF for reimbursement,** **please attach copies of all insurance/Medicare Explanation of Benefits or prescription/eyeglass invoices** to indicate what portion of the bill your insurance carrier has paid.

I, _____**,** do hereby certify under penalty of perjury that this is a true and correct claim for necessary expenses incurred by me, and that no payment has been received by me on account thereof; that I am an:

☐ **Active** ☐ **Inactive member of the:**

☐ Benton City Police Department
☐ Prosser Police Department
☐ Benton County Sheriff's Department
☐ West Richland Police Department
☐ Benton County Fire District No. 1

and that the following attached prescription(s), doctor bill(s), and/or hospital bill(s) were required for treatment of (describe disability) _____, which was ordered by Dr. _____.

And that I am eligible for reimbursement under the following plans:

☐ Benton-Franklin Medical Services
☐ WCIP
☐ Regence Northwest Health
☐ Social Security (Medicare-Medicaid)
☐ _____ Insurance
☐ _____ Pension Plan
☐ _____ Other

and that sickness or disability was not caused or brought on by dissipation or abuse.

Date of Service	Pharmacy, Doctor, and/or Hospital	Total Amount Submitted to Insurance	Amount Paid by Insurance	Patients Responsibility	Line of Duty? Y/N

**NOTE: All LEOFF Plan members are ultimately responsible for hospital and medical accounts, and any late charges added as a result of overdue payments.

_____ SIGNATURE

_____ DATE

FOR DISABILITY BOARD USE ONLY

☐ Approved ☐ Disapproved

_____ CHAIRMAN

_____ MEMBER

_____ MEMBER

_____ MEMBER

_____ MEMBER

_____ MEMBER