City of Mercer Island
LEOFF 1 Disability Board Medical Claim Form

LEOFF 1 Retiree Information:

Name: **Phone Number:**

Address:

City: **State:** **Zip:**

Reimbursement Request Information:

Service Date	Provider	Service Received (Prescription, medical appt, etc.)	Uncovered Cost
			$
			$
			$
			$
			$
		Total	$ $ 0.00

I have not received compensation for these medical expenses and if compensation is forthcoming from a source other than the City of Mercer Island, I will reimburse the City immediately for those expenses. To the best of my knowledge the above information is true and correct.

Claimant Signature

Date Submitted

Save a copy of this form to your computer before closing, so you can upload it or attach it to your submission email.

Submission must include the following:

- Completed Disability Board Medical Claim Form.
- Itemized statement from the service provider indicating any insurance or other payments made to the provider.
- In some cases, it may be required to submit the insurance carrier's "Explanation of Benefits" (EOB) form and Medicare Statement for any claim submitted by a member covered by Medicare.
- Provide billing invoice if expense is not covered by insurance with explanation as to why this is a medical necessity. Reimbursement for these claims will be reviewed by the City of Mercer Island Disability Board.

Submit this form with applicable receipts, statements, and "Explanation of Benefits" (EOB) by:

1. Uploading at LiquidFiles
2. Emailing to HR@mercerisland.gov
3. Mailing to: City of Mercer Island
   Attn: Human Resources
   9611 SE 36th Street
   Mercer Island, WA 98040

Questions? Contact:

Mersiha Beganovic, Senior Human Resources Analyst
206-275-7792
mersiha.beganovic@mercerisland.gov

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