MEDICAL CLAIM FORM
KCDRB Form 10A
LEOFF-1 Assessment of Need for Home Health Care: Claimant or Power of Attorney

Form 9A to be completed by Claimant or POA; Form 9B to be completed by the Director of Nursing or Assisted Living; Form 9C to be completed by facility medical director physician or resident's primary health care provider. Submit all three forms directly to your LEOFF-1 employer. If you have questions call the employer or the King County Disability Retirement Board at 206-684-1556

This section to be completed by LEOFF-1 Claimant or Power of Attorney

Name of LEOFF-I member/claimant: ______________________ Phone: __________

Residence street address: ______________________________________

City: ______________________ State: __________ ZIP: __________

Power of Attorney (POA): ______________________ Phone: __________

POA street address: ______________________________________

City: ______________________ State: __________ ZIP: __________

Home Health Care Agency: ______________________________________

Type of care provided (24-hour care, hospice, medical treatments, other): ______________________

____

Charges for additional services/equipment: ☐ Yes ☐ No If "Yes," list type(s) of service and name(s) of service provider(s):

____

____

Attach itemized statement showing each service, cost and date provided (**required**).

Name of carrier: ______________________ Policy No.: __________

Signature: ______________________ Date: __________

LEOFF-I member/claimant or power of attorney

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.

Revised 3/2020

MEDICAL CLAIM FORM
KCDRB Form 10B
LEOFF-1 Assessment of Need for Home Health Care: Home Health Care Provider or Agency

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Form 10A to be completed by Claimant or POA; Form 10B to be completed by the home care provider; Form 10C to be completed by primary health care provider. Submit all three forms directly to your LEOFF-1 employer. If you have questions call your employer or the King County Disability Retirement Board at 206-684-1556.

This form to be completed by home health care provider or agency.

Service provider: ______________________________ Phone: ______________

Agency street address: ____

City: ______________________________ State: __________ ZIP: __________

State licensure of agency **(copy required)**: ☐ Yes ☐ No

Professional liability insurance? **(copy required):** ☐ Yes ☐ No

Carrier and policy number: ______________________________

Licensure/certification of caregivers **(copy of certificate for each caregiver required)**: ☐ Yes ☐ No

Hourly rates **(copy of rate sheet and itemized invoice for services provided required)**:

____

Prescribing health care provider or physician: ______________________________

Current level of care required **(copy of care plan required)**: ______________________________

____

Medical treatments provided: ______________________________

____

Signature: ______________________________ Date: ______________
Home health care or agency supervisor

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Revised 3/2020

MEDICAL CLAIM FORM
KCDRB Form 10C
LEOFF-1 Assessment of Need for Home Health Care: Prescribing Physician or Primary Health Care Provider

Form 10A to be completed by Claimant or POA; Form 10B to be completed by the home care provider; Form 10C to be completed by primary health care provider. Submit all three forms directly to your LEOFF-1 employer. If you have questions call your employer or the King County Disability Retirement Board at 206-684-1556.

This form to be completed by prescribing physician or primary health care provider.

(Dictate for typing or print ONLY.)

Name of patient: ____________________

Prescribing health care provider: ____________________ Phone: ____________

Prescribing health care provider address: ____________________

City: ____________________ State: ____________ ZIP: ____________

Diagnosis upon admission to home health care: ____________________

____

____

History of illness/condition leading up to home health care: ____________________

____

Patient's prognosis for recovery: ____________________

____

Current level of functioning: ____________________

____

Current medications (please attach printed list to include name, dosage, frequency):

____

____

Other providers involved in patient's health care: ____________________

____

____

What treatment services have been prescribed (physical therapy, speech therapy, etc.)? Attach treatment plans for ***each*** service **(required).**

____

____

____

Signature: ____________________ Date: ____________
Prescribing physician/primary health care provider (mm/dd/yyyy)

____
Printed Name

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