MEDICAL/DENTAL CLAIM FORM
KCDRB Form 7
LEOFF-I Physician/Dentist/Health Care Provider's Statement

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

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

Patient's name: _____ Insurance/HMO: _____

Employer: _____ Insurance billed? ☐ Yes ☐ No

Employer's Street Address: _____ Telephone: _____

City: _____ State: _____ ZIP: _____

Health care provider: _____

Provider's 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's Treatment Plan.")

_____

_____

☐ In addition, I have attached a current medical, dental, or audiogram 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/dentist/health care provider

_____
Printed Name

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.