MEDICAL CLAIM FORM
KCDRB Form 8
LEOFF-I Physician/Health Care Provider's Treatment Plan

(To be completed by providers of mental health, chiropractic and substance abuse treatment exceeding one month or in the case of additional medical services continuing for more than two visits for the same illness or condition.)

Please mail this form to the patient's employer at the address provided below within one month of initiation of treatment. If you have questions, call the employer or the King County Disability Retirement Board at 206-684-1556.

Patient's name: _____

Employer: _____

Employer's Street Address: _____ Telephone: _____

City: _____ State: _____ ZIP: _____

Health care provider: _____

Provider's Street Address: _____ Telephone: _____

City: _____ State: _____ ZIP: _____

The treatment plan needs to be designed as an **individualized** plan to meet the unique treatment requirements of the patient while including, but not being limited to, the categories suggested below. Please feel free to attach additional sheets as needed.

Diagnosis

Current medical diagnostic information (for mental health condition DSM IV, 5-digit code plus other axes involved and any relationship to the condition.)

_____

_____

Significant History

_____

_____

Prescribed Medication

Dosage, frequency, side effects, estimated length of treatment.

_____

_____

Description of Treatment or Therapy

Treatment modality, frequency, length of treatment session, estimation of duration, approximate recovery time, criteria indicating progress, additional professionals/therapists providing supplemental or alternative treatment services.

_____

_____

☐ In addition, I have attached a current medical or audiogram report/evaluation.

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

_____

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.