Allegiance Benefit Plan Management, Inc.

City of Vancouver LEOFF1 Claim/Reimbursement Request

MAIL: ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC., P.O. BOX 3018, MISSOULA, MT 59806

TOLL-FREE CLAIMS FAX: (866) 201-0522 Customer Service: (800) 877-1122

CLAIMANT'S NAME: _____ SSN OR ALT ID#: _____

PLEASE CHECK ONE OF THE FOLLOWING:

- ☐ PAY VENDORS LISTED DIRECTLY
- ☐ REIMBURSE ME FOR CLAIMS PAID

Service Listed	Service Date	Covered by Other Insurance (including Medicare)	Amount of Out of Pocket Expense
		❑Yes ❑ No	
		❑Yes ❑ No	
		❑Yes ❑ No	
		❑Yes ❑ No	

DIRECTIONS: *PLEASE LIST ELIGIBLE MEDICAL SERVICES AND EXPENSES WHICH ARE NOT ELIGIBLE FOR PAYMENT UNDER ANY OTHER COVERAGE, INCLUDING MEDICARE OR OTHER HEALTH INSURANCE COVERAGE. ONLY LIST THE AMOUNT OF THE EXPENSE YOU HAVE TO PAY AFTER INSURANCE PAVS ITS SHARE. IF ANY OF THESE EXPENSES WERE COVERED BY INSURANCE, ATTACH A COPY OF THE "EXPLANATION OF BENEFITS" FROM YOUR INSURANCE COMPANY AND/OR MEDICARE AS DOCUMENTATION. FOR EXPENSES NOT COVERED BY INSURANCE, SEND A COPY OF A BILL OR INVOICE WHICH INCLUDES THE DATE OF SERVICE, YOUR COST, AND ITEMIZED BILLING INFORMATION INCLUDING BILLING CODES SUCH AS CPT AND ICD-9 CODES.*

I certify that these statements are true and that the claimed expenses cover only me. I further understand that expenses reimbursed under this program may not be claimed on my individual tax return at the end of the year.

Claimant's Signature: _____

Date: _____

Has your address changed? New Address:

_____

_____

_____