

# MEDICAL CLAIM FORM

## KCDRB Form 10A

### LEOFF-1 Assessment of Need for Home Health Care

Please submit this form along with Form 10B and Form 10C directly to your LEOFF-1 employer. Your physician must complete Form 10C before your home care provider can complete Form 10B. Both Form 10B and Form 10C must be completed before you can submit Form 10A. If you have questions, call the King County Disability Retirement Board at 206-263-6394, or 206-684-1556 (call center).

**This form to be completed by LEOFF-1 claimant, responsible family member or claimant's legal representative.**

Name of LEOFF-I member: \_\_\_\_\_ Phone: \_\_\_\_\_

Residence street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Responsible family member  
or legal representative: \_\_\_\_\_ Phone: \_\_\_\_\_

Representative 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**).

Insurance purchased for this care?  Yes  No Medicare?  Yes  No

Other medical insurance?  Yes  No

Name of carrier: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
LEOFF-I member, family member or legal representative

**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.**