Print

Reset Form

Rockford Police Relief Association
Medical / Dental Claim Form

Name_____ **Phone #**_____ **Date** _____

Email_____

***PLEASE List each EOB separately, even if there are multiple for one bill.**

****MAIL REQUESTS TO: 557 NEW TOWNE DRIVE ROCKFORD, ILLINOIS 61108**

	Name of Doctor or Facility	M-Medical D-Dental	Date of Service (mm/dd/yyyy)	Amount (List each EOB separately)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
			TOTAL	$ 0.00

If retired, do you have Dental Insurance? Yes ☐ **No** ☐ ***If No see below.**
Is this a work-related injury that is being denied by Workman's Comp? YES ☐ NO ☐
Do you have a Secondary Insurance Carrier? Yes ☐ **No** ☐ **, if yes please list the Insurance Carrier's Name:** _____

This claim has not been approved by the audit committee for the following reason(s):

- ☐ The Medical or Hospital Bill is not included.
- ☐ The Explanation of Benefits (EOB) is not included.
- ☐ The Bill and the EOB are different amounts (please explain why and re-submit).
- ☐ Exceeds annual $2500.00 Maximum for the Year
- ☐ Exceeds annual $1000.00 Dental Limit
- ☐ Eye exams must be performed by an Ophthalmologist
- ☐ Other _____

AUTHORIZED BY (INITIAL)			
Charles Carlson		Al Semenchuk	
Mike Cloyd		Scott Oswald	
Tom Gibbons		Anthony Piccirilli	
Charles Jackson		Marc Welsh	

QUESTIONS? PLEASE CALL
Andrew Hartman – Cell: 815-494-2384
Chris Boeke – Cell: 815-520-0355
Mike Cloyd – Cell: 815-543-0603

Non-Insured Dental claims are paid annually in January the following year.

Rev 01-2023