

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	

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 \$3,000.00 maximum for the current year
- ☐ 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	
Brad Stein			

QUESTIONS? PLEASE CALL
Andrew Hartman – Cell: 815-494-2384

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