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Rockford Police Relief Association
Auditing Committee

Name_____ **Phone #**_____

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 (month/day/year)	Amount (List each EOB separately)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
			TOTAL	**$0.00**

****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 $2000.00 Maximum for the year
- ☐ Exceeds annual $750.00 dental limit
- ☐ FYI Non Insured Dental claims are paid annually in January the following year.
- ☐ Eye exams must be performed by an Ophthalmologist
- ☐ Other _____

QUESTIONS? PLEASE CALL

AUTHORIZED BY (INITIAL)			
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