Dental Claim Form
WCDRB Form 11
LEOFF-1 Dental Expense Form

(To be completed by LEOFF 1 member.)

To request approval of dental expenses incurred or to seek pre-approval of future treatment, complete the WCDRB Form 11 and attach an invoice for services completed or an estimate of planned work. If you carry dental insurance, you invoice must be submitted to that insurance first. **Only amounts not covered by insurance can be claimed**. Submit all paperwork to the LEOFF-1 Board Clerk for direct reimbursement and/or payment directly to the provider. If you have questions, call the Whatcom County LEOFF Board at 360-788-5200.

Patient's Name: _____

Street Address: _____ Telephone: _____

City: _____ State: _____ ZIP: _____

Dentist's Name: _____

Street Address: _____ Telephone: _____

City: _____ State: _____ ZIP: _____

Service Date	ADA Code	Description	Amount
		AMOUNT TO BE PAID BY LEOFF BOARD	

I HEREBY ATTEST that, to the best of my knowledge, the above information is true and correct. I hereby authorize a service provider who has treated me for this condition to release my medical records to the Whatcom County LEOFF Disability Board or its designee. Furthermore, I hereby consent to examination by any other physician(s) the Board may require. I understand that this consent is given only for the purpose of establishing my right to LEOFF-I benefits. I hereby certify that this claim is for necessary expenses incurred by me and that no payment has been received by me on account thereof. I further attest that dental services rendered were solely for non-cosmetic reasons

Signed: _____ Date: _____
LEOFF-I Member

Please sign in blue ink.

The Whatcom County Disability Retirement Board for LEOFF-1 will only accept original 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.