



LRFA

PO Box 8857
Elkins Park, PA 19027

T 215.635.4137 / info@LRFA.org
F 215.635.1583 / www.LRFA.org

FOR LRFA USE ONLY

Benefits paid: \$ _____ Plan: _____ %: _____

Approved by: _____ Date: _____

HEALTH SUPPLEMENTAL PLAN Benefit Request Form

1. Person <u>requesting benefits</u> Last name First name MI LRFA Membership #				
2. Person <u>receiving care</u> Last Name First Name Date of birth (mm/dd/yyyy)				
3. Address				
City	State	Zip Code	Phone	E-mail
4. If the expenses are a result of an accident at work, has Workers Comp or other coverage been billed? <p style="text-align: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>				
5. Do you have other primary health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, have they paid their portion? <input type="checkbox"/> YES <input type="checkbox"/> NO				
6. Dates of Service:				
<input type="checkbox"/> Hospitalization (in-patient) From _____ to _____ (month, day, year) (month, day, year)		<input type="checkbox"/> Out-patient care From _____ to _____ (month, day, year) (month, day, year)		
7. Diagnosis or nature of illness or injury (Please attach treatment and examination bills): _____ _____ _____ _____ _____				
8. I have enclosed treatment and examination bills for the following amounts:				
Hospital: \$ _____				
Physician: \$ _____				
Other _____ : \$ _____				
TOTAL: \$ _____				

9. I hereby certify that the above information is true and correct to the best of my knowledge.	
Signature of person requesting benefits _____	Date _____