LRFA

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FOR LRFA USE ONLY
Benefits paid: $_____ Plan: _____
Approved by: _____ Date: _____

Hospital Supplemental Cash Plan Benefit Request Form

1. Person requesting benefits Last name | First name | MI | LRFA Membership #

2. Person receiving care 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?

☐YES ☐NO

5. Do you have other primary health insurance? ☐YES ☐NO **If YES, have they paid their portion?** ☐YES ☐NO

6. Dates of Service:

☐ **Hospitalization (in-patient)**
From _____ (month, day, year) to _____ (month, day, year)

☐ **Out-patient care**
From _____ (month, day, year) to _____ (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