KCK FIREFIGHTER'S RELIEF ASSOCIATION
HEARING AID REIMBURSEMENT CLAIM FORM

(ATTACH COPIES OF PAID RECIEPTS)

THE KCK FIREFIGHTER'S RELIEF ASSOCIATION WILL REIMBURSE UP TO $400 EVERY 24 MONTHS FOR DURABLE MEDICAL GOODS THAT ARE NECESSARY AS A RESULT OF SERVICE CONNECTED INJURIES FOR ACTIVE MEMBERS.

CLAIMS SHOULD BE SENT TO:
KCKFRA, 815 N. 6TH STREET, KANSAS CITY, KS 66101
QUESTIONS: CHAD WOMBLE (913) 645-9466

NAME____________________________PHONE_________________
ADDRESS____
CITY, STATE______________________________ZIP_____________

PHYSICIAN'S STATEMENT

____IS AN ACTIVE FIRE FIGHTER AND HAS BEEN REQUIRED TO WORK IN CONDITIONS AND ATMOSPHERES THAT CAUSE HEARING LOSS. THERE IS NO SINGLE EPISODE OF INJURY, HOWEVER, REPEATED EXPOSURE TO LOUD NOISES (SUCH AS SIRENS AND ENGINE NOISE) HAVE CULMINATED IN THIS PATIENT'S NEED FOR HEARING AIDS. THIS CONDITION SHOULD BE CONSIDERED TO BE SERVICE CONNECTED.

PHYSICIAN'S NAME____

ADDRESS____

PHYSICIAN'S SIGNATURE____________________________________DATE___________

AUTHORIZATION

I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY, INSURANCE COMPANY OR OTHER ORGANIZATION, INSTITUTION OR PERSON, THAT HAS ANY RECORDS OR KNOWLEDGE OF MY HEALTH CONCERNING HEARING LOSS TO GIVE TO THE KANSAS CITY, KANSAS FIREFIGHTER'S RELIEF ASSOCIATION, OR IT'S REPRESENTATIVES, ANY SUCH INFORMATION.

CLAIMANT'S SIGNATURE___________________________________DATE__________

(FOR OFFICE USE ONLY)

DATE OF LAST REIMBURSEMENT FOR DURABLE MEDICAL GOODS:______________
AMOUNT OF REIMBURSEMENTS WITHIN PAST 24 MONTHS:________________
TOTAL OUT OF POCKET – THIS CLAIM:__________________
TOTAL APPROVED REIMBURSEMENT:___________________
OFFICERS SIGNATURE_______________________________DATE:____________