

**LATVIAN RELIEF FUND OF AMERICA, INC.**  
P O Box 8857, Elkins Park, PA 19027-0857  
Phone: (215) 635-4137; Fax: (215) 635-1583  
e-mail: [ALPF@comcast.com](mailto:ALPF@comcast.com), website: [www.LRFA.org](http://www.LRFA.org)

<u>FOR LRFA USE ONLY</u>	
M -1 \$	_____
M-B \$	_____
M -2 \$	_____
M -3 \$	_____
M-3D \$	_____
M-4 \$	_____
M-4D \$	_____
<b>TOTAL paid: \$</b>	_____
_____	_____
Authorization date	Signature

**MEDICARE SUPPLEMENTAL PLAN**  
**BENEFIT CLAIM FORM**

I hereby submit the following information in accordance with LRFA Medicare Supplemental Plan and request the payment of corresponding benefits:

**Personal information:**

- 1. Last name** \_\_\_\_\_ **LRFA memb. #.** \_\_\_\_\_

**First name** \_\_\_\_\_ **Medicare #** \_\_\_\_\_

**Date of birth** \_\_\_\_\_ **Phone #** \_\_\_\_\_ **e\_mail** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_
- 2. Diagnosis or nature of illness or injury** \_\_\_\_\_

( \_\_\_\_\_

\_\_\_\_\_

- 3. Enclosed:** \_\_\_ Your Explanation of MEDICARE Benefits

\_\_\_ MEDICARE Summary Notice

\_\_\_ Your Record of Part B MEDICARE Benefits Used

\_\_\_ MEDICARE Benefit Notice

\_\_\_ Hospital Statement

\_\_\_ Prescription drug receipts / „itemized statement of dispensed drugs” / Drug profile.

**Date :** \_\_\_\_\_ **Signature:** \_\_\_\_\_