# 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 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 ☐N/A

**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