



LRFA

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FOR LRFA USE ONLY

Benefits paid: \$ _____ Plan: _____ %: _____
Approved by: _____ Date: _____

HOSPITAL SUPPLEMENTAL CASH 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 _____	