

MEDICAL EXPENSES CLAIM FORM EMD-084

(See WAC 118-04-320 for detailed instructions)

**Washington Military Department
Emergency Management Division**

CLAIMANT'S INSTRUCTIONS:

1. This form is in three parts: **Part One** must be completed by the emergency worker; **Part Two** must be completed by the local emergency management director; and, **Part Three** must be completed by the attending physician.
2. All responses **must be in ink** and all requested items **must be completed**. **DO NOT PRINT TWO-SIDED**
3. Claimant **must be a registered Emergency Worker** in accordance with Revised Code of Washington (RCW) 38.52, and Washington Administrative Code (WAC) 118-04, and must have been working under Emergency Management authority at the time of the accident.
4. A state **Mission number, Training Mission number, or Evidence Search Mission number** must have been assigned.
5. **Receipts or other documentation** for all claimed items **must be included**. Fasten receipts smaller than 8.5x11 inches to letter size paper. For multiple receipts provide a summary sheet.
6. **Claimant MUST be registered as a Payee (Vendor)** with the Department of Enterprise Services, Statewide Payee Desk (see: <http://www.des.wa.gov/services/ContractingPurchasing/Business/VendorPay/Pages/default.aspx>). **Enter Statewide Vendor Number (SVN) below**
7. When completed, **this form must be signed by claimant or claimant's representative**.
8. If claimant is unable to present and file the claim (due to incapacitation, etc.) or if claimant is a minor, or a nonresident of the state, the claim may be presented and filed on behalf of the claimant by any relative, attorney, or agency representing the claimant.
9. If medical treatment or care will continue for an extended period, **contact your local Director of Emergency Management or SAR Coordinator** for guidance on preparing the claim.
10. **Submit original claim and all supporting documentation to your local Director of Emergency Management or Search and Rescue Coordinator (WAC 118-04-360).**

PART ONE:

TO BE COMPLETED BY EMERGENCY WORKER (CLAIMANT) OR REPRESENTATIVE

NAME OF CLAIMANT: _____
Last First M.I.

EMERGENCY WORKER CARD NUMBER: _____

CLAIMANT'S ADDRESS: _____
City State Zip

COUNTY WHERE REGISTERED: _____

HOME PHONE: () _____

WORK PHONE: () _____

STATEWIDE VENDOR/PAYEE NUMBER (SVN) : _____ EMAIL: _____

DATE & TIME DEPARTED HOME: _____ DATE & TIME RETURNED HOME: _____

COUNTY WHERE MISSION OCCURED: _____ MISSION OR INCIDENT # _____ DATE OF INCIDENT: _____

TOTAL AMOUNT OF CLAIM: \$ _____

FULL DESCRIPTION OF CIRCUMSTANCES SURROUNDING THE INCIDENT AND A DESCRIPTION OF THE INJURY(S) RECEIVED AS A RESULT: _____

(If more space is needed, please attach additional sheets)

**PART THREE:
TO BE COMPLETED BY ATTENDING PHYSICIAN**

NAME OF INJURED EMERGENCY WORKER: _____

DATE OF FIRST TREATMENT: _____

WAS HOSPITALIZATION REQUIRED? [YES] [NO]

IF YES, NAME AND ADDRESS OF HOSPITAL: _____

HISTORY OF INJURY (if extremities involved, give right or left): _____

(If more space is needed, please attach additional sheets)

PHYSICAL FINDINGS IN DETAIL (if extremities involved, give right or left): _____

(If more space is needed, please attach additional sheets)

X-RAY FINDINGS: _____

DIAGNOSIS: _____

IF THE ILLNESS, INJURY, OR TREATMENT, AS DESCRIBED, IS RELATED TO ANY PREVIOUS ILLNESS, INJURY, OR TREATMENT; OR THAT THERE IS EVIDENCE OF PREEXISTING INJURY OR DISEASE OF THE AREA; OR THAT A PREEXISTING CONDITION WILL COMPLICATE TREATMENT, PLEASE EXPLAIN IN DETAIL: _____

WILL THIS WORKER BE OFF OF WORK DUE TO INJURY? [YES] [NO]

IF YES, ESTIMATE TIME LOSS FROM REGULAR JOB DUE TO INJURY: _____ DAYS

WILL THERE BE ANY PERMANENT DISABILITY? [YES] [NO]

IF YES, EXPLAIN: _____

ATTENDING PHYSICIAN: PLEASE PRINT OR TYPE YOUR NAME AND ADDRESS:

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: () _____

PATIENT ACCOUNT#: _____

PHYSICIAN'S SIGNATURE

DATE

(THIS REPORT CAN BE ACCEPTED ONLY WHEN COMPLETED AND SIGNED BY A LICENSED PHYSICIAN)