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.

CLAIMANT'S ADDRESS: _____

_____
City State Zip

EMERGENCY WORKER CARD NUMBER: _____

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)

If Time Was Lost From Work:

Actual or Estimated Time Lost (dates): _____

Gross Monthly Salary: $ _____

Full Time (Y/N) _____ Part Time (Y/N) _____ If part time, number of hours per week: _____

Full Name of spouse at the Time of Incident: _____

If Divorced, Final Decree Date: _____

NOTE: If divorced and you have minor children, submit a copy of the court order showing legal custodian of such children. Also, give present address of such custodian. ***Give name and birth date of your children under 18 supported by you.***

FULL NAME	RELATIONSHIP	DATE OF BIRTH MO. | DAY | YEAR

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

WAS THE INCIDENT COVERED BY PRIVATE INSURANCE? [YES] [NO]

IF YES, NAME, ADDRESS AND POLICY NUMBER OF INSURANCE COMPANY: _____

_____

_____

WAS A PORTION OF THE INCIDENT DEDUCTIBLE FROM THE POLICY BENEFIT? [YES] [NO]

HAVE YOU MADE A CLAIM AGAINST THE INSURER? [YES] [NO]

HAVE YOU MADE A SETTLEMENT WITH THE INSURER? [YES] [NO]

IF SO, WHAT AMOUNT? $ _____

EMERGENCY WORKER (CLAIMANT) OR LEGAL REPRESENTATIVE MUST SIGN THIS FORM

I hereby certify or "declare" under penalty of perjury under the laws of the State of Washington that the foregoing is a true and correct claim for necessary expenses incurred by me or claimant and that no payment has been received by me or claimant on account thereof.

_____ _____ _____

Signature of Emergency Worker (Claimant) Date Address

_____

City County State

If the Claimant is incapacitated from verifying, presenting, and filing the claim or if the claimant is a minor, or is a nonresident of the state, the claim may be verified, presented, and filed on behalf of the claimant by any relative, attorney, or agent representing the claimant. All claims for damages against the state arising out of tortuous conduct shall be presented to and filed with the Risk Management Office.

(NOTE: For general statutory provisions governing claims against the State of Washington, see chapter 4.92.100 RCW. For specific information regarding Emergency Management Worker Claims, see chapter 38.52 RCW)

PART TWO

To Be Completed By The Emergency Management/Services Director For The Jurisdiction Where Claimant Is Registered Or For The Jurisdiction Where Incident Occurred.

I have reviewed the information in part one (1) and it is true to my best knowledge and belief.

_____ _____

Director's Signature Date

Don't forget to check:

[ ] Copy of EMD-078 with Emergency Worker name showing? [ ] Receipts as specified included? [ ] Form(s) properly filled out and signed?

If total claim for mission/incident number exceeds $2,000.00, before sending in the claim, a compensation board must be established in accordance with RCW 38.52.210. Contact Washington Emergency Management Division for further information.

Mail completed form with all documentation to:

State SAR Coordinator
Emergency Management Division
Washington Military Department
Camp Murray WA 98430-5122

Form EMD-084 (Rev. 04/14) All other versions are obsolete and should not be used.

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)