MEDICAL CLAIM REIMBURSEMENT FORM-ASBESTOS WORKERS WELFARE FUND

LAST NAME________________________________

	PATIENT NAME	DATE OF SERVICE	SERVICE CODE	PAYMENT TYPE	PAYMENT AMOUNT	For office use only ADM. APPROVE	For office use only WF FUND CHECK #
1)							
2)							
3)							
4)							
5)							
6)							
7)							
8)							
9)							
10)							
11)							
12)							

SIGNED________________________________ DATE______________ TOTAL $______________