WF Retirees'

Adult Custodial Care Claim Form

Bodon, Inc.
9101 E. Chenango Ave.
Greenwood Village, CO 80111
(855) 937-3847 (call or Fax)
lynn@WFRetirees.com

Date: _____

Member

Name: _____ DOB _____/_____/_____

I certify the charges for the medical services which are listed herein, for which the invoices are attached, and for which payment has already been made were incurred by the member on account of the member. Misrepresentation may disqualify member from future benefits.

I hereby authorize the release of information contained in, or pertaining to this claim to the Administrator, Trustee, or any of their authorized representatives for purposes of settlement of this claim.

Person Completing Claim

Name: _____ Relation: _____

Signature: _____ Telephone: _____

Send reimbursement to: _____

_____

_____

List below a brief description of the invoices for which reimbursement is requested. Enclose a copy of each invoice with a copy of proof of payment.

Date of Invoice	Service Provider	Brief Description of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____