

Family Fund for Paralyzed and Disabled Officers

A support program of the National Association of Chiefs of Police



Claim for Medical Reimbursement

INSTRUCTIONS

- To request reimbursement, please submit the following to the address listed on this form (any missing information may result in delay or denial of the request):
 - Completed and signed Reimbursement Form
 - Proof of services rendered
 - Proof of payment for the services being requested for reimbursement up to \$500.
- Reimbursement requests are processed within 60 days. Incomplete requests will take longer.
- Reimbursement will be sent to the applicant at the address provided on this form.
- Those eligible to request reimbursement claims are: permanently disabled law enforcement officers enrolled in the Disabled Police Officers Fund (DPOF) .
- Retain a copy for your records.

PERSONAL INFORMATION

| | | |
|------------------------|--------------|----|
| Last Name | First Name | MI |
| Street Address | | |
| City/State/Zip | | |
| Date of Birth | Phone Number | |
| Email Address | | |
| Law Enforcement Agency | | |

CLAIM INFORMATION

| Date of Service | Provider Name | Amount |
|---------------------|---------------|--------|
| | | |
| | | |
| | | |
| Total Reimbursement | | |

I have read and understand all information on the application and affirm that all the information submitted is true and accurate to the best of my knowledge. I also agree that the National Association of Chiefs of Police (NACOP) have my permission to use my photo and information to promote the medical reimbursement program in their mail and on-line campaigns.

Signature _____ Date _____

Submit this form and all documentation to:
 Medical Reimbursement Fund
 National Association of Chiefs of Police
 6350 Horizon Drive
 Titusville, FL 32780

For more information, you may contact us at (321) 264-0911, janetc@aphf.org or visit nacoponline.org.