Everett Police Pension Board Meeting Agenda

April 15, 2026, 9:00 a.m. via Microsoft Teams

1.) Approval of minutes for March 18, 2026

2.) Bills and Pension Rolls:

PENSION ROLL		
Budgeted Amount	$450,000.00	
February 2026	$38,529.03	
Remaining budget	**$374,115.57**	**83.14%**
MEDICAL CLAIMS		
Budgeted amount	$1,565,000.00	
February 2026	$115,099.74	
February 2026 HMA fees	$11,896.56	
Remaining budget	**$1,261,192.49**	**80.59%**

3.) Action Item:

Member #108 Reimbursement request for seat lift in the amount of $2087.

Police Pension Board Minutes
City Of Everett
March 18, 2026

DRAFT

The regular meeting of the Police Pension Board was called to order at 9:05 a.m. on March 18, 2026. Board Members Poon, Sebald, Neighbors, Thiessen, and Jorve were in attendance. Board Members Franklin and Schwab were excused. Chelsi Bardwell, Human Resources; Rick Gray, Finance; and David Hall, Board Attorney were also in attendance.

APPROVAL OF MINUTES

The minutes of the meeting of January 21, 2026, were approved.

BILLS AND PENSION ROLLS

PENSION ROLL		
Budgeted Amount	$515,000.00	
December 2025	$39,702.66	
Remaining budget	**$23,672.87**	**4.60%**
MEDICAL CLAIMS		
Budgeted amount	$1,410,000.00	
December 2025	$103,001.72	
December 2025 HMA fees	$11,001.90	
Remaining budget	**$187,181.33**	**13.28%**
PENSION ROLL		
Budgeted Amount	$450,000.00	
January 2026	$37,355.40	
Remaining budget	**$412,644.60**	**91.70%**
MEDICAL CLAIMS		
Budgeted amount	$1,565,000.00	
January 2026	$164,914.65	
January 2026 HMA fees	$11,896.56	
Remaining budget	**$1,388,188.79**	**88.70%**

Moved by Neighbors, seconded by Thiessen, to approve the pension rolls as presented.

Roll was called with all members voting yes, except Board Members Franklin and Schwab who were excused.

Motion carried.

Moved by Thiessen, seconded by NIeghbors, to approve the medical claims as presented.

Roll was called with all members voting yes, except Board Members Franklin and Schwab who were excused.

Motion carried.

ACTION ITEMS

Member #152 Request reimbursement of $214.05 for physical therapy exceeding yearly cap.

Moved by Thiessen, seconded by Nieghbors, to approve the request for Board Member #152.

Roll was called with all members voting yes, except Board Members Franklin and Schwab who were excused.

Motion carried.

OTHER:

Process for reimbursement reminders

Presented by Chelsi Bardwell, HR

Discussion ensued regarding end of life and requests for visits by board members and Genworth cost of care and finding that information on the website.

The Board meeting adjourned at 9:20 a.m.

_____
Marista Jorve, Board Secretary

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name
(please print) [redacted]

1. Diagnosis: _____

2. Prognosis: _____

3. Type of Treatment(s) or Procedure: Seat Lift

4. Cost of treatments/service: $ 2087.00

5. Request to the board for this specific treatment or procedure:

Police member $108, fell and had surgery for arm, wrist, and elbow. Lift seat was needed to move and sleep on it. Medicare denied claim for not going through a medicare approved facility and HMA denied due to seat lifts not covered.

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

HMA

Member Reimbursement Claim Form

Patient Information

First Name [redacted] **Last Name** [redacted]

Date of Birth [redacted] **Member ID Number**[1] [redacted]

Group/Employer Name City of Everett **Group Number**[1] 920188

Service Type

Please select the type of service for which you're requesting reimbursement. If more than one service type applies, you must submit a separate claim form for each. If you're completing this form electronically, your selection here drives which information will be marked as required in the "Attachments" and "Claim Information" sections below.

Service Type Select... medical reimbursment

Attachments

Please include all relevant documentation (such as an itemized receipt, bill, and/or invoice) with your submission. The checkboxes below indicate which information your documentation must contain for each service type. **Failure to provide the requested information may cause your claim to be delayed or denied.**

- [x] **Required for all service types:** Date(s) of service and total amount you were billed for each service rendered / equipment purchased
- [ ] **Required for all service types *except* durable medical equipment (DME) purchased through a store (not purchased through a certified DME vendor):** Patient name, provider full name and mailing address, including city, state, and ZIP code, procedure codes such as CPTs or HCPCs, and one or both of the following: Provider's national provider identifier (NPI) number, provider's tax ID number (TIN)
- [ ] **Required for all service types *except* DME purchased through a store and massage therapy:** Diagnosis code(s), in ICD format

Claim Information

Please enter all necessary information below or ensure it's listed on the documentation you're attaching with your submission such as an itemized receipt, bill, and/or invoice. **Failure to supply all the required information may cause your claim to be delayed or denied.**

↓ Check each applicable box below if you're including an attachment that contains this information. If so, no need to also write the information below.

- [ ] **Date(s) of Service**[2] 5/9/2025
- [ ] **Total Billed Amount** 2087.00
- [ ] **Provider Name** Erickson furniture
- [ ] **Provider Mailing Address**

  City Everett **State** WA. **ZIP Code** 98201
- [ ] **Procedure or Service Codes (such as CPTs or HCPCs)**[3] ⊖
- [ ] **Diagnosis Codes (in ICD format)**[4] ⊖
- [ ] **Provider's NPI Number**[5] **and/or Tax ID Number (TIN)**[6] ⊖

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1 This information can be located on your insurance ID card. "Member ID" is also called "Employee ID".

2 For DME you purchased through a store, this is the purchase date.

3 Procedure/Service Code (CPT/HCPC) is usually a five-digit number that describes the services/products provided.

4 Diagnosis Code (ICD) is usually a three- to seven-character alphanumeric code that indicates the reason for your healthcare treatment.

5 National Provider Identifier (NPI) is a unique 10-digit ID issued to U.S. healthcare providers by the Centers for Medicare and Medicaid Services (CMS). If you don't know your provider's NPI, please contact your provider to obtain it before submitting your claim for reimbursement. If you submit your claim without this information, it might be denied if we're unable to verify your provider.

6 Tax Identification Number (TIN) is a unique 9-digit ID issued by the IRS. If you don't know your provider's TIN, please contact your provider to obtain it before submitting your claim for reimbursement. If you submit your claim without this information, it might be denied if we're unable to verify your provider.

HMA

Member Reimbursement Claim Form

Instructions

Please use this form if requesting reimbursement for claims related to all medical, dental, and vision services covered by Healthcare Management Administrators (HMA), your third-party Health Plan Administrator. For prescription claims, contact your pharmacy benefits manager (PBM). You will need to complete and submit this form only if your health care professional isn't filing the claim for you. Your health care professional can still file the claim for you if they are out-of-network with your policy; however, they are not required to do so.

Please include a copy of your itemized receipt, bill, and/or invoice with your completed claim form. Your submission must contain all necessary information based on the type of service for which you're requesting reimbursement. The minimum necessary information for each type of service is described below in the "Attachments" section.

☒ I understand that my claim for reimbursement might be delayed or even denied if I haven't provided all the information needed to process my claim.

Note: Providers who are contracted with a PPO Network that is accessible and utilized by your Health Plan are contractually required to bill your Plan and be paid directly by the Plan for services they provide to you. If you have received services from a provider who is in your Plan's PPO Network, we will remit payment to the provider, even if you indicate you want reimbursement to go to you. If you have already paid the provider for your care, you will need to contact them to arrange for a refund, if applicable. Moving forward, be sure to provide your providers with your insurance card so they can bill your Plan directly.

Any questions? We are here to help! Contact Customer Care at 800-869-7093.

Submission Information

Please choose one of the following methods below for submitting your claim reimbursement request (pick any option that works for you):

Electronic Submission Options

✓ **Option 1: DocuSign**:

1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Scroll to **Member Reimbursement Claim Form** and click **Complete Online**
3. Complete and submit the form and a copy of your itemized receipt, bill, and/or invoice through DocuSign

✓ **Option 2: HMA Member Portal**:

1. Login to the member portal at https://memportal.accesshma.com/login
2. In the member portal, click on **Manage Claims & Deductibles**, click on **Submit a Claim**, and follow the prompts - be sure to upload a copy of your itemized receipt, bill, and/or invoice

Paper Submission Options

1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Scroll to **Member Reimbursement Claim Form** and click **Download pdf**
3. Fill out the form in compatible PDF software like Adobe Reader or Acrobat (it is not recommended to try filling out the form in a web browser or on a mobile device, as the form may not work correctly) or print out the form and fill it out by hand
4. Use one of the submission options below:

   ✓ **Option 1: Fax** the completed form and a copy of your itemized receipt, bill, and/or invoice to: 866-458-5488

   ✓ **Option 2: Mail** the completed form and a copy of your itemized receipt, bill, and/or invoice to:
   HMA
   Attn: Claims Department
   PO Box 85008
   Bellevue, WA 98015-5008

HMA

Member Reimbursement Claim Form

Accident Information

Is This Claim Due to an Accident? ◯ No (skip to next section) ☒ Yes (fill out this section)

Accident Date 5/5/25 **Accident Location** ◯ Home ◯ Work ◯ School ◯ Auto ☒ Other _____

How Did the Accident Happen? fell over a curb on a walk

Are You Filing a Claim with Labor & Industries (L&I), Homeowner/Auto Insurance, or Any Other Party? ◯ Yes ◯ No

Signature

Note: It's a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

By signing below, I indicate the following:

- ☒ I certify that the information I provided on this form is true and complete to the best of my knowledge.
- ☒ I expressly authorize any provider of care to provide Healthcare Management Administrators with any records concerning me or any member of my family for whom benefits or services have been claimed.
- ☒ I understand that my claim for reimbursement might be delayed or even denied if I haven't provided all the information needed to process my claim.

[redacted]

Printed Name (First and Last)

Relationship to Patient (If you are the patient, put "Self")

[redacted]

3/9/2026

Date

ERICKSON
FURNITURE
5 BROADWAY, EVERETT, WA 98201
Phone: (425) 259-3876 Fax: (425) 259-4693
www.ericksonfurniture.com

FIRST NAME	[redacted] MIDDLE INITIAL
STREET ADDRESS	[redacted]
CITY	[redacted] STATE ZIP CODE [redacted]
EMAIL	CELL PHONE [redacted] HOME PHONE

SALESPERSON	CITA
DATE WRITTEN	5/9/25
WILL CALL	
DELIVERY	✓
DAY	FRI
DATE	5/9

SOLD MEF: NEW ☐ PRIOR ☒

QTY	STOCK NUMBER	DESCRIPTION	AMOUNT	
1	1C559-L	Ultra Comfort Lift Recliner	1899	00
	NOAH MAIZE			

PROTECTION PLAN: (please initial) _____ ACCEPTED _____ DECLINED PLAN#_____

SPECIAL ORDERS - *We will attempt to estimate the date of arrival of your order; however, we cannot be held responsible for delays due to items out of stock at [redacted] various manufacturing and shipping problems beyond our control.*

SPECIAL INSTRUCTIONS AND [redacted]ONS

TERMS & CO[redacted]ONS - SEE BACK OF INVOICE FOR DETAILS

FINANCE CO. [redacted]

If this order is cancelled by customer, down payment may be forfeited to Erickson Furniture. You, the buyer, agree that purchase of the goods or services described in this sales invoice will be governed by the revolving charge agreement between you and us, the seller. You promise to pay the amount financed shown on this invoice plus finance charges and all other charges as of this sales invoice. Buyer also understands and agrees to the conditions of sale printed on the reverse side of buyer's invoice copy.

[redacted]

I HEREBY ACKNOWLEDGE THE RECEIPT OF THE ABOVE ARTICLES IN GOOD ORDER

C.O.D. AMOUNT TO COLLECT $	1. DELIVERY CHARGES		
	2. SUB TOTAL OF MERCHANDISE	1899	00
AMOUNT COLLECTED $ 7087 00 VISA	3. SALES TAX	189	00
	4. TOTAL PURCHASE PRICE (SUM OF LINES 1, 2 & 3)	7087	00
DR. INITIALS	5. DOWN PAYMENT DEPOSIT WITH ORDER		
	6. UNPAID BALANCE OF PURCHASE PRICE (LINE 4 LESS LINE 5)		

WHITE – ORIGINAL COPY YELLOW – STORE COPY PINK – CUSTOMER COPY

Applied to deductible	Coinsurance	You may be billed
$0.00	$0.00	$0.00

Review your MSN for important information about the cost of this service.

Summary

Total amount charged
$1,899.00

The amount your provider charged Medicare.

Total Medicare approved
$0.00

The amount Medicare agreed to pay your provider for the services provided.

Blood deductible
$0.00

You must pay a deductible for the processing and handling of the first 3 pints of blood you get in a calendar year. This is added to any other amounts you owe on this claim.

Physical therapy charges
$0.00

The amount your provider charged for physical therapy services.

Psychiatric charges
$0.00

The amount your provider charged for psychiatric services.

Occupational therapy charges
$0.00

The amount your provider charged for occupational therapy services.

Total patient paid the provider

$1,899.00

The amount you paid the provider for the services you got. This amount includes any copays and coinsurance payments.

Total Medicare paid you
$0.00

The amount Medicare paid you directly for the services you got because the provider didn't accept Medicare's approved amount.

Total Medicare paid the provider
$0.00

The amount Medicare paid the provider.

Total applied to deductible
$0.00

You must meet your 2025 Part B deductible of $257.00 before Medicare begins to pay.

\+ Total coinsurance
$0.00

After meeting your annual Part B deductible, you'll typically pay 20% of Medicare's approved amount for covered equipment and services.

This amount might include any charges Medicare doesn't cover, like denied services.

=

Total you may be billed

Check MSN for total

What you need to pay. It's the total cost of your deductible, copayments, coinsurance, and any charges Medicare doesn't cover.

Learn more about Medicare costs.

Your claim information will be available in your account before you get your Medicare Summary Notice (MSN). Your claims might not be fully processed yet, so there could be differences in the amounts here and the claim summary when you get your MSN.

Explanation of benefits

The Medicare Summary Notice (MSN) is the official summary of your Medicare claims.

What's included in your MSN:

- The final costs for this claim
- Other claims from the same period
- How to handle denied services or file an appeal

What's the deadline to appeal this claim:

120 days after you get your MSN

Get your MSNs electronically

The Medicare Summary Notice (MSN) is the official summary of your Medicare claims. If you choose to get your MSNs electronically, you won't get printed copies of your MSNs in the mail. You'll get an email each time you have a new electronic MSN available, instead of waiting several months for a paper copy.

Sign Up for Your Electronic MSNs

Helpful resources

File a claim, appeal, or complaint

Report fraud and abuse

What's the Medicare Summary Notice (MSN)?

Talk to someone

Need help beyond what's on Medicare.gov?

You can talk or live chat with a real person, 24 hours a day, 7 days a week (except some federal holidays).

Call us at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Start a Live Chat

Medicare.gov

A federal government website managed and paid for by the U.S. Centers for Medicare and Medicaid Services.
7500 Security Boulevard, Baltimore, MD 21244

Medicare.gov

Menu

Durable medical equipment claim

Print Learn about DME claims

Claim #25252150006000

Date of service
05/09/25

Provider
Not available

Provider address
Not available

Claim processed on
10/06/25

Practicing providers
Not available

Medicare Summary Notice (MSN)
Order MSN

Feedback

Services

Service (procedure code)
SEAT LIFT MECHANISM, ELECTRIC, ANY TYPE (E0627)

Qty	Provider charged	Medicare approved
1	$1,899.00	$0.00

Media Information

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0679
Expires 02/2024

CERTIFICATE OF MEDICAL NECESSITY
CMS-849 — SEAT LIFT MECHANISM

DME 07.03A

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ F

[redacted]

SUPPLIER NAME, ADDR [redacted]

Pvdr:SCHAFFER, NATHANI
Date 6/18/25

(___) ___ - ___ NSC or NPI #_____

PLACE OF SERVICE _____ | Supply Item/Service Procedure Code(s): | PT DOB ___/___/___ Sex ___ (M/F) Ht. ___(in) Wt ___

NAME and ADDRESS of FACILITY *If applicable (see reverse)*

PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI #

(___) ___ - ___ UPIN or NPI #_____

SECTION B: Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 *(99=LIFETIME)* | DIAGNOSIS CODES: _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISM (Check Y for Yes, N for No, or D for Does Not Apply)
☐Y ☒N ☐D	1. Does the patient have severe arthritis of the hip or knee?
☐Y ☒N ☐D	2. Does the patient have a severe neuromuscular disease?
☐Y ☒N ☐D	3. Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home?
☒Y ☐N ☐D	4. Once standing, does the patient have the ability to ambulate?
☐Y ☒N ☐D	5. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy) been tried and failed? If YES, this is documented in the patient's medical records.

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C: Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (see instructions on back)

SECTION D: PHYSICIAN Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE 6/11/25

Signature and Date Stamps Are Not Acceptable.

Form CMS-849 (06/19)

Document Information

Misc Clinical: Orthopedics - Other

CERTIFICATE OF MEDICAL NECESSITY

06/13/2025 2:21 PM

Attached To:

External Document on 6/13/25 with HIM SCANNED DOCUMENT

Source Information

HIM SCANNED DOCUMENT