



FEMA

PAPERWORK BURDEN DISCLOSURE NOTICE

Public reporting burden for this data collection is estimated to average 10 minutes per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and submitting this form. This collection of information is required to obtain or retain benefits. You are not required to respond to this collection of information unless a valid OMB control number is displayed on this form. Send comments regarding the accuracy of the burden estimate and any suggestions for reducing the burden to: Information Collections Management, Department of Homeland Security, Federal Emergency Management Agency, 500 C Street, SW, Washington, DC 20472-3100, Paperwork Reduction Project (1660-0002) **NOTE: Do not send your completed form to this address.**

FEMA Director Name

Governor's Name

FEMA Title

Governor's Title

FEMA Directorate Reference

State of (State Name)

National Processing Service Center

00/00/0000

P.O. Box 10055

Hyattsville, MD 20782 – 7055

FEMA Application Number.000000000

Disaster Number: 0000

Applicant Name

Applicant Street Address

Applicant City, State, Zip

Dear Applicant Name:

Our records indicate you may have a need for the type(s) of assistance listed below. However, we need additional information to process your application. Please provide the following information within 21 days of the date of this letter:

Medical expenses:

1. Statement from provider(s) must verify the date the medical injury or illness occurred and if it is disaster related.
2. Name, address, telephone number, and policy number of your medical/health insurance carrier including Medicaid, Medicare and Veterans Administration benefits. **CLAIM MUST BE FILED WITH YOUR INSURANCE CARRIER BEFORE SUBMITTING IT TO US FOR CONSIDERATION.**
3. You must submit either the written denial from your insurance carrier, or the explanation-of-benefits statement(s) for the amount(s) which they have covered.
4. If you are NOT covered by any health/medical insurance, please sign and date the enclosed Statement of Insurance form and return it to us with the following information:
 - Name, address, and telephone number of provider(s) of

- service(s).
- Itemized bills/receipts (NOT STATEMENTS) from the provider(s) of service(s).
 - Date of loss of PRESCRIPTION MEDICATION.
 - Receipts from the pharmacy showing the replacement cost of the medication.
 - Written verification from the pharmacy showing the prescription was filled prior to the disaster.
 - Written verification from your physician stating that your condition requires the medication.

Mail your documents to:

FEMA – Applicant Services

National Processing Service Center

P.O. Box 10055

Hyattsville, MD 20782-8055

Fax your documents to:

1-800-827-8112

OR Attention: FEMA – Applicant Services

Include your FEMA Application Number and Disaster Number on all pages of your documents. Both numbers are printed at the top of the first page of this letter. Keep all originals for your records.

If we do not receive the information within 21 days, we will deny your request for this assistance and you will not be eligible.

If you have any questions, please call FEMA’s Helpline at 1-800-621-FEMA (3362). For people who are deaf, hard of hearing or with speech disabilities, the TTY is 1-800-462-7585.

Sincerely,

Individual Assistance Branch Director

RFI

Applicant Name
Applicant Street Address
Applicant City, State, Zip

00/00/0000
Disaster No.
Page Number 1 or
Registration #

MEDICAL ENCLOSURE

STATEMENT OF MEDICAL INSURANCE:

None of the individuals that I listed on my Disaster Assistance Application and that I have requested assistance for, were covered by health/medical insurance at the time of the disaster-related injury/illness loss. No one was covered by Medicaid, Medicare, Veterans Administration benefits nor did anyone have any other insurance, which would reimburse me for expenses incurred for which I am seeking disaster assistance.

Applicant's Signature: _____

Date: _____

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