LEOFF Application for Payment of Services Case No: 21-1

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: _____ Active: _____ Retired: X

Member Telephone: _____ Police: _____ Fire: X

Member Address: _____

Alternate Contact/Phone: _____ Email: _____

Describe Your Condition and Why It Is Duty Related: tooth implant replacement Not duty related

Describe the Service/Treatment Requested: install pin in jaw lower right to anchor crown

Total Cost of Treatment/Service: $ 2500.00

Amount Paid by Insurance/Medicare: $ 0.

Amount Requested from the Board $ _____. Approved amount?

LEOFF member-Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the amount paid for this treatment/service.

Member Signature: _____ Date: 1-4-21

Please attach a copy of the Power of Attorney if signed by the alternate contact.

B) This Section To Be Completed by Member's Attending Health Care Provider

Provider's Name: Joseph Moss Provider's Telephone: 360-357-8075

Clinic/Office Name: Olympia Advanced Dentistry

Provider's Address: 1105-4th Ave E Olympia, Wa 98506

Describe the Patient's Current Condition and State Whether It Is Duty Related: Crown on #30 fractured off. Non-restorable.

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: Tooth #30 had an old crown with root canal. Crown and tooth fracture w/ large decay on distal root non-restorable. Needs ext./graft and implant to replace #30.

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs: The only other resonable alternative would be to extract and not replace. This would create a lack of function and tooth movement. Highly Recommend implant.

Provider's Signature: _____ Date: 1/5/2021

Fax completed form to: (360) 709-2735 or
Mail to: City Of Olympia HR Dept, PO Box 1967, Olympia WA 98507-1967

→

Olympia Advanced Dentistry

Name [redacted]

.: TREATMENT CASE

Implants #30, #14

DATE	VISIT	TOOTH	SURF	CODE	PROV	DESCRIPTION	FEE	PATIENT
02/26/2019	1	14		D6058	XX01	Abutment supported porc/cer crn	1400.00	1400.00
02/26/2019	1	14		D6097	XX01	Abut sup crown-prc fus-titanium	0.00	0.00
						Visit 1 Totals:	1400.00	1400.00
02/26/2019	3	#30		D6010	XX01	Surg place implant endosteal	2600.00	2600.00
						Visit 3 Totals:	2600.00	2600.00
02/26/2019	4	14		D6057	XX01	Custom abutment-incl placement	650.00	650.00
						Visit 4 Totals:	650.00	650.00
02/26/2019	5			D6190	XX01	Radiograph/surg impl index B/R	350.00	350.00
						Visit 5 Totals:	350.00	350.00
02/26/2019	7	30		D6057	XX01	Custom abutment-incl placement	650.00	650.00
02/26/2019	7	30		D6058	XX01	Abutment supported porc/cer crn	1400.00	1400.00
						Visit 7 Totals:	2050.00	2050.00
02/26/2019	8	30		D6097	XX01	Abut sup crown-prc fus-titanium	0.00	0.00
						Visit 8 Totals:	0.00	0.00

www.coopermossdentistry.com
1105 4th Ave E, Suite A
Olympia, WA 98506 PHONE:

:: INSURANCE PROVIDER(S) ::

Primary	Secondary

:: TOTALS ::

Fee	Patient
7050.00	7050.00

:: FINANCIAL SUMMARY ::

Treatment Plan Total	7050.00
Estimated Deductible to be Applied	0.00
Estimated Insurance Payment	0.00
Estimated Patient's Portion	7050.00
Patient Balance	0.00

:: DENTAL INSURANCE BENEFITS ::

		Patient		Family	
		Primary	Secondary	Primary	Secondary
Annual plan benefits		0.00	0.00	0.00	0.00
Paid Benefits YTD		0.00	0.00	0.00	0.00
Pending Insurance Estimate YTD		0.00	0.00	0.00	0.00
Estimated Benefits Remaining YTD		0.00	0.00	0.00	0.00
Benefits Expire		NA	NA		
Deductible Owed YTD	Standard	0.00	0.00	0.00	0.00
	Preventative	0.00	0.00	0.00	0.00
	Other	0.00	0.00	0.00	0.00

Alternate Cases:

Case notes:

By signing below, I acknowledge that the amount set forth above as payable by my dental insurer is only an estimate, and that it is my responsibility to pay the total fees for the above-described treatment if my insurance company denies coverage. At the time of treatment, I agree to pay the amount indicated above as the patient's portion. If there is any remaining balance after my insurance has been processed, I agree to pay such remaining balance upon receipt of a billing statement

Any balance not paid within 90 days of the date of actual treatment shall accrue interest at a rate of 1.5 percent per month and be considered a Delinquent Account. All payments made after 90 days shall be applied first to interest, and then to any outstanding treatment balance. Cooper Moss Advanced Dentistry reserves the right to submit a Delinquent Account for legal collection. The prevailing party in any proceeding to collect a Delinquent Account shall be entitled to reasonable attorneys' fees and costs related to such proceeding.

REPORT DATE: 01/26/2021

STATEMENT OF ACCOUNT

Olympia Advanced Dentistry
1105 4th Avenue East, Suite A
Olympia, WA 98506-4018

(360)357-8075

CHART NO.	PAGE NO.
100879	1

BILLING DATE
01/26/2021

GUARANTOR NAME AND MAILING ADDRESS

[redacted]

AMOUNT ENCLOSED
$

TO ENSURE PROPER CREDIT, PLEASE DETACH AND RETURN THIS PORTION OF THE STATEMENT WITH YOUR PAYMENT

PLEASE RETAIN THIS PORTION OF THE STATEMENT FOR YOUR RECORDS

DATE	DESCRIPTION	PATIENT'S NAME	CHARGES	CREDITS
11/01/2020	Balance Forward		0.00	
11/12/2020	D6010:Surg place implant: endosteal	[redacted]	2600.00	
11/12/2020	Senior Citizen Courtesy			-260.00
11/12/2020	Online Credit Card - Thank You			-2340.00
11/17/2020	00000:Office Visit		0.00	

PRIOR BALANCE		CURRENT CREDITS		CURRENT CHARGES		NEW BALANCE
0.00	-	-2600.00	+	2600.00	=	0.00

Did you know we are accepting new patients? We would love to care for your friends and family!