[redacted]

RECEIVED
FEB 8 2018
CITY OF OLYMPIA
HUMAN RESOURCES DEPT.

LEOFF Application for Payment of Services Case No: 2-18

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: [redacted] Active: _____ Retired: X

Member Telepho[redacted] Police: X Fire: _____

Member Addres[redacted] NW OLYMPIA 98502

Alternate Contact/Phone: [redacted] Email: [redacted]

Describe Your Condition and Why It Is Duty Related:
NOT DUTY RELATED

Describe the Service/Treatment Requested: TOOTH EXTRACTION, IMPLANT & CROWN

Total Cost of Treatment/Service: $ 4732.-

Amount Paid by Insurance/Medicare: $ 191.- EST.

Amount Requested from the Board $ 4732.- 4532.00

LEOFF member-Please at[redacted]tement(s) from your insurance provider(s) and/or Medicare which [redacted]eatment/service.

Member Signature: [redacted] Date: 1/29/18

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: ERIC J KLEIN, M Provider's Telephone: 360-352-2909

Clinic/Office Name: WEST OLYMPIA INTERNAL MEDICINE

Provider's Address: 110 DELPHI RD OLYMPIA, WA 98502

Describe the Patient's Current Condition and State Whether It Is Duty Related:
ABSCESS TOOTH

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary:
Extraction of tooth followed by implant
Untreated would to further infection + illness

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:
NONE

Provider's Signature: [redacted] Date: 2/5/18

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

W:\LEOFF\FORMS\Application for Payment of Services 2012B.docx 4/20/2012

[redacted] LEIN MD RECEIVED 01/30/2018 03:21PM

Russell & Bode Family Dentistry

Name [redacted]

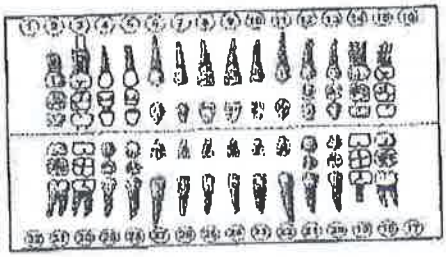
.: TREATMENT CASE

Treatment Plan (1)

DATE	VISIT	TH	SURF	CODE	PROV	DESCRIPTION	FEE	PAT	PRI INS
01/24/2018	1	3		D4266	07DR	Guided tiss regen-resorb-per	381.00	381.00	0.00
01/24/2018	1	3		D7210	07DR	Extract, erupted th, rem oth	306.00	115.00	191.00
01/24/2018	1	3		D7953	07DR	Bone repl grft ridge prsv/site	356.00	356.00	0.00
						Visit 1 Totals:	1043.00	852.00	191.00
01/24/2018	2			D0364	07DR	CT Capture, Lmtd View < 1 Jaw	100.00	100.00	0.00
						Visit 2 Totals:	100.00	100.00	0.00
01/24/2018	3	3		D6010	07DR	Surg place implant: endosteal	1550.00	1550.00	0.00
						Visit 3 Totals:	1550.00	1550.00	0.00
01/24/2018	4	3		D6057	07DR	Custom abutment-incl placement	758.00	758.00	0.00
01/24/2018	4	3		D6058	07DR	Abutment supported porc/cer crn	1272.00	1272.00	0.00
						Visit 4 Totals:	2030.00	2030.00	0.00

:: INSURANCE PROVIDER(S) ::	
Primary	Secondary
DELTA DENTAL OF WISCONSIN	

:: TOTALS ::			
Fee	Pat	Pri Ins	
4723.00	4532.00	191.00	



:: FINANCIAL SUMMARY ::

Treatment Plan Total	4723.00
Estimated Deductible to be Applied	50.00
Estimated Insurance Payment	191.00
Estimated Patient's Portion	4532.00

:: DENTAL INSURANCE BENEFITS ::

		Patient		Family	
		Primary	Secondary	Primary	Secondary
Annual plan benefits		1000.00	0.00	0.00	0.00
Paid Benefits YTD		809.00	0.00	809.00	0.00
Pending Insurance Est. YTD		0.00	0.00	0.00	0.00
Est. Benefits Remaining YTD		191.00	0.00	0.00	0.00
Benefits Expire		03/31/2018	NA		
Deductible Owed YTD		50.00	0.00	0.00	0.00
	Standard	0.00	0.00	0.00	0.00
	Preventative	0.00	0.00	0.00	0.00
	Other				

Alternate Cases:

Case notes:

DATE: 01/24/2018

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