LEOFF Board Application for Payment of Services

Case No: 24-3

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: Active: Retired:

Member Telephone: Police: Fire:

Member Address:

Alternate Contact: Alternate Contact Telephone:

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

Describe the Service/Treatment Requested: crown, extraction & implant

Total Cost of Treatment/Service: $ ~~4189.00~~

Amount Paid by Insurance/Medicare: $ ~~1060.30~~

Amount Requested from the Board $ ~~3128.70~~ 2436.50

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:

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
(attach additional pages as needed)

Provider's Name: Dr. Bode Provider's Telephone: 360 742-3912

Clinic/Office Name: Russell and Bode Family Dentistry

Provider's Address: 2006 Caton Way SW Olympia, WA 98502

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

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary:
prevent further

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

Provider's Signature: [signature] Date: 12/6/23

Fax Completed Form to: (360) 709-2735 or mail to: City Of Olympia HR Dept, PO Box 1967, Olympia WA 98507-1967

Revised 12/27/07

SINGLE PATIENT LEDGER

Russell Maynard Bode Family Dentistry

Date: 12/06/2023 Page: 1

Patient Name

Chart Number: 500304

Billing Type: 1

DATE	TEETH	DESCRIPTION	PATIENT	CHARGE	PAYMENT	BALANCE
						0.00
08/28/2023		Patient Balance Forward		0.00		23.00
* 08/29/2023		D0220:Intraoral Periapical Images		23.00		86.00
* 08/29/2023		D0140:Limited oral evaluation		63.00		162.00
* 08/29/2023	20	D2920:Re-cement or re-bond crown		76.00		362.00
* 09/07/2023		D0364:CT Capture, Lmtd View < 1 Jaw		200.00		585.00
* 09/07/2023	30	D7210:Ext Surgical		223.00		2554.00
* 09/07/2023	30	D6010:Surg place implant: endosteal		1969.00		2910.00
* 09/07/2023	30	D6104:Bone Graft, Implant Placement		356.00		2910.00
* 09/14/2023	29	D2740:CROWN, PORCELAIN/CERAMIC PREP		0.00		2770.80
* 09/14/2023		Dental Ins Payment - Delta Dental of OR			-139.20	2659.30
* 09/14/2023		Dental Ins Payment - Delta Dental of OR			-111.50	2853.30
* 09/14/2023	29	D2950:Core buildup, include any pins		194.00		2853.30
* 09/28/2023		D4999:PE		0.00		2984.30
* 09/28/2023		D4910:Periodontal maintenance		131.00		4069.30
* 09/28/2023	29	D2740:Crown - porcelain/ceramic		1085.00		3933.50
^ 09/29/2023		Dental Ins Payment - Delta Dental of OR			-135.80	3260.00
10/16/2023		Dental Ins Payment - Delta Dental of OR			-673.50	

TOTAL PATIENT BALANCE AS OF 12/06/2023: 3260.00

* Pd 12/21/23 #824.00

Ins Pmt — Patient

#29 $542.00 135.80

$131.00

#30 $53.20 22.80

$86.00

#30 $111.50

City Pay

Both #29 $1279.00 601.30

Maint 131.00 —

76.00 22.80

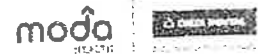
Both #20

xray + exam 286.00 200.00

* Tooth #30 2548.00 $2436.50
will submit to board for approval

* Procedures that have been placed in History.
^ Prior period adjustments - entered for a month that has been closed.

Welcome partrinj



Benefit Tracker

Dental search | EOPs | Documents | Find Care

Claim Detail 2325428579-00

Eligibility and Benefits | Procedure utilization | Group limitations | Claims | Member handbook

ID number:
Subscriber name:

Insurance type: Delta Dental PPO (exclusive)
Group number: 10010328
Group name: Oregon Individual Dental

Provider: Bode, William C.
P00000957073
Claim number: 2325428579-00

Claim detail

DATES	TOOTH	TOTAL CHARGES	NON-COVERED CHARGES	DEDUCT	PROVIDER DISC/ DISALLOW *	REMAINING COVERED CHARGES *	COPAY/ COINS *	PT RESP *	TOTAL BENEFIT	BENEFIT PD TO PROV	CODES
9/7/23	Cone Beam Code: D0364										
		$499.00	$499.00	$0.00	$0.00	$0.00	$0.00	$499.00	$0.00	$0.00	ARC/Remark
9/7/23	Implant Services Code: D6010										
	30	$2,525.00	$2,525.00	$0.00	$0.00	$0.00	$0.00	$2,525.00	$0.00	$0.00	ARC/Remark
9/7/23	Implant Services Code: D6104										
	30	$840.00	$840.00	$0.00	$0.00	$0.00	$0.00	$840.00	$0.00	$0.00	ARC/Remark
9/7/23	Oral Surgery Code: D7210										
	30	$441.00	$0.00	$0.00	$218.00	$223.00	$111.50	$111.50	$111.50	$111.50	ARC/Remark
Totals:	---	$4,305.00	$3,864.00	$0.00	$218.00	$223.00	$111.50	$3,975.50	$111.50	$111.50	---

CHECK / CLAIM #	CHECK PAYEE	AMOUNT	DATE	COMBINED CHECK	EOP
EFT	Russell and Bode DDS PLLC	$250.70	09/12/2023	Yes	

Reason code:
9A0 - This service is not covered.
9B1 - Provider discount has been applied.
204 - The service/equipment/drug is not covered under the patient's current benefit plan.
45 - Charges exceed fee schedule / maximum allowable amount or contracted / legislated fee arrangement.

* These columns are not a part of the HIPAA standard.

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For Oregon insured plans, prior authorization for benefit coverage and medical necessity shall be binding if obtained no more than 60 days prior to the date the service is provided, and eligibility shall be binding for 5 business days from the date of the authorization except in the case of fraud or misrepresentation. For other plans, services are subject to eligibility and plan provisions.

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