LEOFF Board Application for Payment of Services

Case No: _____

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: [redacted]

Member Telephone:

Member Address:

Alternate Contact: _____ Alternate Contact Telephone: _____

Describe Your Condition and Why It Is Duty Related: COMPLETE UPPER DENTAL PLATE MAXILARY

Describe the Service/Treatment Requested: Comprehensive Eval-CD Preliminary Impressions-Complete Denture-Maxillary

Total Cost of Treatment/Service: $ 3621.00

Amount Paid by Insurance/Medicare: $ 0

Amount Requested from the Board $ 3621.00

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 RICK JUDE DMD Provider's Telephone: 360-438-0711

Clinic/Office Name: PROSTHETIC DENTISTRY OF OLYMPIA

Provider's Address: 3641 ENSIGN RD. NE. #6-A, OLYMPIA, WA.

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

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

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:

Provider's Signature: _____ Date: _____

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

SINGLE PATIENT LEDGER

Prosthetic Dentistry of Olympia

COPY

Date: 05/07/2025

Patient Name: [redacted]

Chart Number: JO0049

Billing Type: 1

DATE	TEETH	DESCRIPTION	PATIENT	CHARGE	PAYMENT	BALANCE
04/02/2025		Patient Balance Forward	[redacted]	0.00		0.00
04/03/2025		Comprehensive oral evaluation		243.00		243.00
04/03/2025		Credit Card Payment-Thank you			-243.00	0.00
04/24/2025		Treatment Consult		0.00		0.00
04/29/2025		CD/ Preliminary Impressions		0.00		0.00
05/07/2025	2-15	Complete denture - maxillary		3378.00		3378.00
05/07/2025		Credit Card Payment-Thank you			-3378.00	0.00

TOTAL PATIENT BALANCE AS OF 05/07/2025: 0.00

STATEMENT OF SERVICES RENDERED

Prosthetic Dentistry of Olympia
Rick Jude, DMD
3641 Ensign Rd. NE #6-A
Olympia, WA 98506
(360)438-0711

CHART NO.	PAGE NO.
JO0049	1

BILLING DATE
05/07/2025

GUARANTOR NAME AND MAILING ADDRESS

[redacted]

COPY

PATIENT	TOOTH	SURF	DESCRIPTION	CHARGE	CREDIT
[redacted]			~~Complete denture - maxillary~~	~~3378.00~~	-3378.00
			Credit Card Payment-Thank you		

Prosthetic Dentistry of Olympia
Invoice #281238872

May 7, 2025 1:07:07 PM

Express Item x1	$3,378.00
Subtotal	$3,378.00
Tax	$0.00
Total	**$3,378.00**

[redacted]

Application Label: VISA CREDIT
BRIC #: 07XMBXB9EGX5KT6ZMDY
Approved Online
AID: A0000000031010
AC: B278CBB46DC8BC89
Response Code: 00

Prosthetic Dentistry of Olympia
3641 Ensign Rd. NE; Suite A6
Olympia, WA 98506
(360) 438-0711
www.rickjudedmd.com
manager@rickjudedmd.com

CUSTOMER COPY

REDITS	CURRENT CHARGES	NEW BALANCE	DENTAL INS. EST.	PLEASE PAY
	~~3378.00~~	~~0.00~~	~~0.00~~	~~0.00~~
	+	=	-	=

y 29 2025	3:30 pTIME	CD/ tryin	REASON

STATEMENT OF SERVICES RENDERED

Prosthetic Dentistry of Olympia
Rick Jude, DMD
3641 Ensign Rd. NE #6-A
Olympia, WA 98506
(360)438-0711

CHART NO.	PAGE NO.
JO0049	1

BILLING DATE
04/03/2025

GUARANTOR NAME AND MAILING ADDRESS
[redacted]

SURF	DESCRIPTION	CHARGE	CREDIT
	~~Comprehensive oral evaluation~~	~~243.00~~	-243.00
	Credit Card Payment-Thank you		

CREDITS	CURRENT CHARGES	NEW BALANCE	DENTAL INS. EST.	PLEASE PAY
0	243.00	0.00	0.00	0.00
	+	=	-	=

DATE	TIME	REASON

Prosthetic Dentistry of Olympia
Invoice #273781978

Apr 3, 2025 9:05:33 AM

Express Item x1 $243.00

Subtotal	$243.00
Tax	$0.00
Total	**$243.00**

[redacted]

Application Label: US DEBIT
BRIC #: 076M8QBUMBVHJN137A1
Approved Online
AID: A0000000980840
AC: 86EA1EF3FFAA4A17
Response Code: 00

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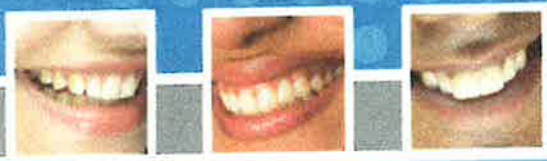
manager@rickjudedmd.com

CUSTOMER COPY

Rick A. Jude, DMD

Name [redacted]
Birthdate
Social Security Number
Chart Number



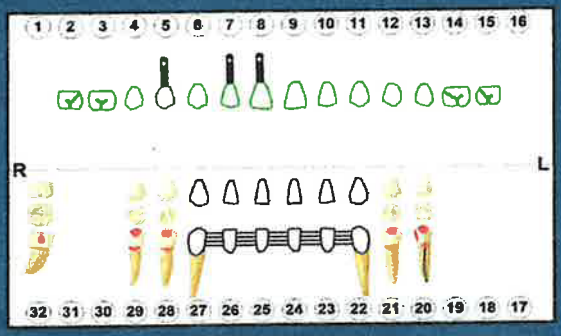
:: TREATMENT CASE

Treatment Plan

DATE	VISIT	TOOTH	SURF	CODE	PROV	DESCRIPTION	FEE	PATIENT
04/03/2025	0	2-15		D5110	DMD1	Complete removable dentures to replace all upper teeth	3378.00	3378.00
						Visit 0 Totals:	3378.00	3378.00

:: INSURANCE PROVIDER(S) ::	
Primary	Secondary

:: TOTALS ::	
Fee	Patient
3378.00	3378.00



:: FINANCIAL SUMMARY ::

Treatment Plan Total	3378.00
Estimated Deductible to be Applied	0.00
Estimated Insurance Payment	0.00
Estimated Patient's Portion	3378.00
Fee Expiration Date	01/01/2028

:: 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:

The above is an estimation of your recommended treatment. Estimated insurance benefits are listed above (if applicable) and is not a guarantee of payment from your insurance company. Regardless of any estimated insurance coverage, I understand that any fees incurred will be my responsibility and I will keep my account current.

Si[redacted] 4/24/25

Date

www.rickjudedmd.com

3941 Erbil Rd NE
Olympia, WA 98506
PHONE 360-459-0141