LEOFF Board Application for Payment of Services

Case No: 24-2

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

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

Member Telephone: [redacted] Police: _____ Fire: X

Member Address: [redacted]

Alternate Contact: _____ Alternate Contact Telephone: _____

Describe Your Condition and Why It Is Duty Related: TOOTH 19 DECAY UNDER AT ROOT BELOW GUM LINE. PRIMARY DENTIST DR MERCHANT HAVE TOOTH REMOVED AND IMPLANT TAKE ITS PLACE

Describe the Service/Treatment Requested: EVALUATION AND REMOVAL OF TOOTH #19 AND IMPLANT INSTALLED. DR WOMACK

Total Cost of Treatment/Service: $ 3657.00

[redacted] $ 1877.00

Amount Requested from the Board $ 5534.00

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. Ryan Womack Provider's Telephone: 360 754-9444

Clinic/Office Name: Capital Orcland Maxillofacial Surgery

Provider's Address: 2008 Caton Way SW Ste 101 Olympia, 98502

Describe the Patient's Current Condition and State Whether It Is Duty Related: Not Duty related

Failing root canal tooth needs

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

Extract tooth #19 place implant + bone graft so patient has adequate chewing surface

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

extract tooth + place bridge - our office does not do this

Provider's Signature: _____ Date: 1-11-24

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

Location: \\Calvin\Personnel\Forms\

Revised 12/27/07

To: LEOFF Pension Board

1/24/24

I submit to you for pre-approval a bill of $5,534.00 for the procedure of removing tooth #19, the installation of inplant, and crown. The procedure will require the services of both Dr. Womac and my dentist Dr. Merchant.

Cost breakdown as indicated on forms attached:

Dr. Womac....Tooth removal, bone graft, and inplant .....$ 3,657.00

Dr. Merchant....installation procedure and crown.....$ 1,877.00

Total.....$5,534.00

Thank you for your time and consideration on this medical / dental issue.

Name: Frank Spickelmire (111905)

Image Name: Signed Tx Plan

Capital Oral and Maxillofacial Surgery
2008 Caton Way SW Ste 101
Olympia, WA 98502 (360) 754-9444

January 11, 2024

The following is an estimation of your recommended treatment. **This estimate is not a guarantee of payment from your insurance company.**

Description	Th#	Fee	Ins%
Ext- Surgical Removal Erupted Tooth	19	285.00	50%
Bone Grft Ridge Preservation	19	388.00	0%
Surgical Implant Body: Endosteal	19	2,142.00	0%
Limited Oral Eval - Problem Focused		103.00	100%
General Anesthesia Add 15 Min		204.00	0%
General Anesthesia Add 15 Min		204.00	0%
Panoramic Film		98.00	100%
Intraoral - Periapical First Film		29.00	100%
Anesthesia First 15 Min		204.00	0%
Total		**3,657.00**	

$1000.00 Yearly Insurance Maximum

Implants, Bone Graft, and Anesthesia are not covered benefits

$1900.00 Deposit is due day of surgery with 3 months to pay balance in full after insurance

A Non-Refundable Fee Will Be Charged For Appointments Cancelled With Less Than 48hr Notice. 15% of procedure.

All Deposits for Surgery Appointments Will Need To Be Collected in Advance To Secure Appointment.

**Regardless of any estimated insurance coverage, I understand that any fees incurred will be my responsibility and I will keep my account current.

Dr. Womack is **Not** a provider with **Medicare** or **Medicaid** and/or any supplements of these insurances. By signing this plan you agree **NOT** to bill these insurances for services provided by our office.

Sign _____ Date JAN 11 2024

Tumwater Family Dentistry

Name

.: TREATMENT CASE

Treatment Plan

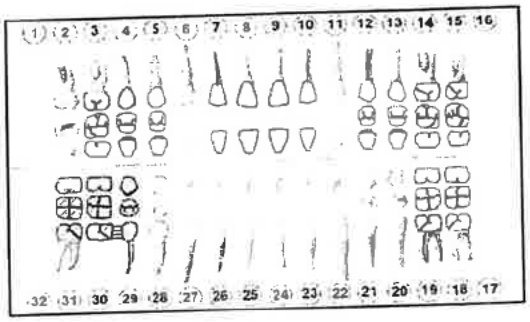
DATE	VISIT	TOOTH	SURF	CODE	DESCRIPTION	FEE	PATIENT	PRIMARY
01/22/2024	0	19		D6057	Custom abutment-incl placement	677.00	677.00	0.00
01/22/2024	0	19		D6058	Abutment supported porc/cer crn	1200.00	1200.00	0.00
					Visit 0 Totals:	1877.00	1877.00	0.00

:: INSURANCE PROVIDER(S) ::

Primary	Secondary
Regence 2023	

:: TOTALS ::

Fee	Patient	Primary
1877.00	1877.00	0.00



:: FINANCIAL SUMMARY ::

Estimated Deductible to be Applied	0.00
Estimated Insurance Payment	0.00
Estimated Patient's Portion	1877.00

Alternate Cases:

Case notes:

Insurance benefits are ESTIMATED based upon information from the insurance company. It is not a guarantee of payment. Patient/Guardian is responsible for amount not paid by insurance. The fees listed above will be valid for up to 30 days.

Patient/Guardian agrees to pay their portion day of treatment. Payment will be made by:

_____Cash/Check _____Visa/MasterCard _____Finance Pgm

_____

Patient/Guardian Signature

_____

Team Member Signature

6939 Littlerock Rd SW Ste. B
Tumwater, WA 98512 PHONE: (360)352-0401

REPORT DATE: 01/22/2024