Case No: 24-7

LEOFF Board Application for Payment of Services

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: X 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: DENTAL CROWN and hygiene prophy, full mouth set Xrays and check up exam

Total Cost of Treatment/Service: $ 3635.00 3760.00

Amount Paid by Insurance/Medicare: $ 0 [redacted]

Amount Requested from the Board $ 3635.00

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: 8/28/24

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: Steven Strauman Provider's Telephone: 760 439 0000

Clinic/Office Name: _____

Provider's Address: 2123 El Camino Real Suite B Oceanside CA 92054

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

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: #30 implant crown needed to restore form and function of missing tooth

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

Provider's Signature: _____ Date: Aug 29 2024

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

Proposed Treatment Plan

Steven M. Streelman, D.D.S

2123 El Camino Real, Suite B
Oceanside, CA 92054
(760)439-0600

ID: 8201

Phase	Date Plan	Appt	Provider	Service		Tth	Surf	Fee	Ins.	Pat.
	8/21/2024		15	02332	Composite Ant. 3 Surfaces	10	MFL	$310.00	$248.00	$62.00
	8/21/2024		15	06057	Custom Abut/Placement - Implant	30	DM	$1,075.00	$0.00	$1,075.00
	8/21/2024		15	06065	Implant - Porc/Cerm Crown	30		$1,850.00	$0.00	$1,850.00
	8/21/2024		15	09944	Occlusal Guard - Hard Full Arch			$525.00	$262.50	$262.50
							Subtotal:	$3,760.00	$510.50	$3,249.50

INSURANCE COVERAGE IS ONLY AN ESTIMATION. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOUR AND/OR YOUR EMPLOYER AND THE INSURANCE CARRIER. I UNDERSTAND THIS IS JUST AN ESTIMATE.

Total Proposed:	$3,760.00
Total Completed:	$0.00
Total Accepted:	$0.00
Proposed Insurance:	$510.50

All patient co-payments are due at the time services are rendered! Thank you.

I AUTHORIZE THE DENTIST TO PERFORM THE TREATMENT DESCRIBE ABOVE. I UNDERSTAND I AM RESPONSIBLE FOR ANY BALANCES NOT PAID BY MY INSURANCE COMPANY. THESE FEES ARE VALID FOR 90 DAYS.

Patient or Guarantor's Signature _____ Date 8/21/24