

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:

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: DENTAL CROWN and hygiene properly, full mouth set xrays and check up exam

Total Cost of Treatment/Service: \$ 3635.00 3760.00

Amount Paid by Insurance/Medicare: \$ 0

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

Provider's Name: STEVEN STREEMAN Provider's Telephone: 760 439 0000

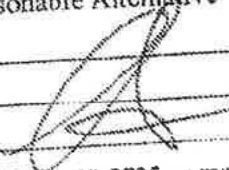
Clinic/Office Name: _____

Provider's Address: 2123 El Camino Real Suite B Occanside 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 on missing tooth

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

Provider's Signature:  Date: Aug 28 2024

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

Proposed Treatment Plan

Steven M. Strelman, D.D.S

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

ID: 8201

<u>Phase</u>	<u>Date Plan</u>	<u>Appt</u>	<u>Provider</u>	<u>Service</u>	<u>Tth</u>	<u>Surf</u>	<u>Fee</u>	<u>Ins.</u>	<u>Pat.</u>
	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