LEOFF Application for Payment of Services Case No: 26-1

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section to Be Completed by LEOFF 1 Member

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

Member Telepho[redacted] Police: ✓ Fire: _____

Member Address: [redacted]

Alternate Contact/[redacted]

Describe Your Condition and Why It Is Duty Related: All issues stem from his inoperable right knee. In this case his upper teeth have ALL broken off, and he's been unable to stand and care for his dental health. Several doctors are concerned for his cardiac, uti, & bowel health resulting from dental infections

Describe the Service/Treatment Requested: It's universally recommended to remove all upper teeth to maintain a minimum of overall health. We will maintain bottom teeth at all effort.

Total Cost of Treatment/Service: $ 7296.—

Amount Paid by Insurance/Medicare: $ _____.—

Amount Requested from the Board $ 7296.—

LEOFF member-Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the

Member Signature:[redacted]

B) This Section To Be Completed by Member's Attending Health Care Provider

Provider's Name: Richard Buck Provider's Telephone: 360-357-9919

Clinic/Office Name: Affordable Dentures and Implants

Provider's Address: 1540 Cooper Point ~~Rd~~ SW Suite 450, Olympia, WA

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

Multple cavities, destroyed dentition / gum infections

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: Remove all upper teeth and remove infection and insert denture

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

alt plan is implat dentures which adds $10,000 to cost

Provider's Signature: Richard Buck DMD Date: 1/9-26

Fax completed form to: (360) 709-2735 or
Mail to: Attn: HR, City Hall, PO Box 1967, Olympia WA 98507-1967

Patient Treatment Case Report

Patient: [redacted]
Provider: Richard Buck, DMD
Phone: (360)357-9919
Office: 1540 Cooper Point Rd
Suite 450
Olympia, WA 98502

Date: 1/9/2026
Chart #: 9256705
SS #:
Birthdate: [redacted]

Case Name: NDWP F/;rab **Priority:** None
Alternate Cases:
Status: Proposed **Last Updated:** 1/9/2026
Comment:
Case Note: The above treatment procedure has been fully explained to me. My questions have been answered to my satisfaction.

Signature: [redacted]

Ent Date	Prc Date	Visit	Tooth	Surface	Code	Prov	Description	Fee	Pat	Prim Ins	Sec Ins
11/6/2025	11/6/2025	1			D1999.6	DR-RIBL	Denture Care Starter Kit	90.00	90.00	0.00	0.00
11/6/2025	11/6/2025	1	1-16		D5130.0	DR-RIBL	NDWP Full UltimateFit-U	2,285.00	2,285.00	0.00	0.00
1/9/2026	1/9/2026	1			99998	DR-RIBL	Pre Op	0.00	0.00	0.00	0.00
							Visit: 1 Subtotal:	**2,375.00**	**2,375.00**	**0.00**	**0.00**

Ent Date	Prc Date	Visit	Tooth	Surface	Code	Prov	Description	Fee	Pat	Prim Ins	Sec Ins
11/6/2025	11/6/2025	2	3		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	4		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	5		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	6		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	7		D7140.3	DR-RIBL	Routine Ext w/ NDWP	109.00	109.00	0.00	0.00
11/6/2025	11/6/2025	2	8		D7140.3	DR-RIBL	Routine Ext w/ NDWP	109.00	109.00	0.00	0.00
11/6/2025	11/6/2025	2	9		D7140.3	DR-RIBL	Routine Ext w/ NDWP	109.00	109.00	0.00	0.00
11/6/2025	11/6/2025	2	10		D7140.3	DR-RIBL	Routine Ext w/ NDWP	109.00	109.00	0.00	0.00
11/6/2025	11/6/2025	2	11		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	12		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	13		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	14		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	15		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	16		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	17		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	19		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
1/9/2026	1/9/2026	2			D0330	DR-RIBL	Full Panoramic X-Ray	100.00	100.00	0.00	0.00
1/9/2026	1/9/2026	2			D7921	DR-RIBL	Coll/App Autologous Blood Conc	350.00	350.00	0.00	0.00
1/9/2026	1/9/2026	2			D9248	DR-RIBL	Non IV conscious sedation	255.00	255.00	0.00	0.00
1/9/2026	1/9/2026	2	UL		D7310	DR-RIBL	Alveoloplasty w/ext 4+, quad	280.00	280.00	0.00	0.00
1/9/2026	1/9/2026	2	UL		D7953.1	DR-RIBL	Bone graft-ridge/sock pres/quad	500.00	500.00	0.00	0.00
1/9/2026	1/9/2026	2	UR		D7310	DR-RIBL	Alveoloplasty w/ext 4+, quad	280.00	280.00	0.00	0.00
1/9/2026	1/9/2026	2	UR		D7953.1	DR-RIBL	Bone graft-ridge/sock pres/quad	500.00	500.00	0.00	0.00
							Visit: 2 Subtotal:	**4,921.00**	**4,921.00**	**0.00**	**0.00**

Ent Date	Prc Date	Visit	Tooth	Surface	Code	Prov	Description	Fee	Pat	Prim Ins	Sec Ins
11/6/2025	11/6/2025	3			99992.2	DR-RIBL	Soft Liner - N/C	0.00	0.00	0.00	0.00
11/6/2025	11/6/2025	3			PSTOP	DR-RIBL	Post-op	0.00	0.00	0.00	0.00
							Visit: 3 Subtotal:	**0.00**	**0.00**	**0.00**	**0.00**

Ent Date	Prc Date	Visit	Tooth	Surface	Code	Prov	Description	Fee	Pat	Prim Ins	Sec Ins

* Recommended Case

Ent Date	Prc Date	Visit	Tooth	Surface	Code	Prov	Description	Fee	Pat	Prim Ins	Sec Ins
11/6/2025	11/6/2025	5			D0002	DR-RIBL	NDWP Final	0.00	0.00	0.00	0.00
							Visit: 5 Subtotal:	**0.00**	**0.00**	**0.00**	**0.00**
Ent Date	**Prc Date**	**Visit**	**Tooth**	**Surface**	**Code**	**Prov**	**Description**	**Fee**	**Pat**	**Prim Ins**	**Sec Ins**
11/6/2025	11/6/2025	6			99992.3	DR-RIBL	Wax Try-In N/C	0.00	0.00	0.00	0.00
1/9/2026	1/9/2026	6			99992.3	DR-RIBL	Wax Try-In N/C	0.00	0.00	0.00	0.00
							Visit: 6 Subtotal:	**0.00**	**0.00**	**0.00**	**0.00**
Ent Date	**Prc Date**	**Visit**	**Tooth**	**Surface**	**Code**	**Prov**	**Description**	**Fee**	**Pat**	**Prim Ins**	**Sec Ins**
11/6/2025	11/6/2025	7			99985	DR-RIBL	Delivery N/C	0.00	0.00	0.00	0.00
							Visit: 7 Subtotal:	**0.00**	**0.00**	**0.00**	**0.00**
							Total:	**7,296.00**	**7,296.00**	**0.00**	**0.00**

Treatment Plan Total	**7,296.00**
Estimated Deductible to be Applied	**0.00**
Estimated Insurance Payment	**0.00**
Estimated Patient's Portion	**7,296.00**

Dental Insurance Benefits		**Patient**	
		Primary	**Secondary**
Annual Plan Benefits		**0.00**	**0.00**
Paid Benefits YTD		**0.00**	**0.00**
Pending Insurance Est. YTD		**0.00**	**0.00**
Est. Benefits Remaining YTD		**0.00**	**0.00**
Benefits Expire			
Deductible Owed YTD	**Standard**	**0.00**	**0.00**
	Preventive	**0.00**	**0.00**
	Other	**0.00**	**0.00**
Primary Dental Insurance			
Secondary Dental Insurance			

Pt must have care giver present to assist in transfering pt to the chair.

* Recommended Case