..Title
Case #15-17 Dental Request

..Report
Issue:
Whether to approve payment for dental work for LEOFF member and what amount.

Staff Contact:
Carl Watts, Personnel Analyst, General Government, Human Resources, 360.753.8305

Background:
The board must decide whether to approve the request for dental work for $597. The member had tooth decay and this caused him to need a crown. Failure to treat would lead to further medical problems. These issues are preventing the member from properly chewing his food. This in turn has an impact on nutrition. The cost exceeds the allowable amount of $600/year for regular dental care. This is in accordance with LEOFF I policies and procedures.

Attachments:
Attachments containing protected medical information will be sent via File Transfer Protocol (FTP)

Reference:
LEOFF Disability Board Policies and Procedures (2009) Paragraph Q, Dental Benefits.

LEOFF Application for Payment of Services Case No: 15-17

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: X Fire: ____

Member Address: [redacted]

Alternate Contact/Phone: [redacted] Email: [redacted]

Describe Your Condition and Why It Is Duty Related: NOT DUTY RELATED

Describe the Service/Treatment Requested: DENTAL CROWN

Total Cost of Treatment/Service: $ 1194.-

Amount Paid by Insurance/Medicare: $ 597.-

Amount Requested from the Board $ 597.-

LEOFF member-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: [signature] Date: 10/3/17

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: Eric J. Klein, M.D. Provider's Telephone: 360-352-2909

Clinic/Office Name: West Olympia Internal Medicine

Provider's Address: 110 Delphi Rd. NW #101 Olympia, WA 98502

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

Dental Decay under Crown

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

Replace Dental Crown

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

none

Provider's Signature: [signature] Date: 10/4/17

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

West Olympia Internal Medicine PLLC
110 Delphi Road NW, Suite 101
Olympia WA 98502
Eric J. Klein, M.D.
360 352 2909

October 26, 2017

Re [redacted]

[redacted] is a long-standing patient of mine. Because of tooth decay he needed to have a crown placed on a decaying tooth. Failure to treat this infection would lead to further medical problems. For this reason this should be considered a medical necessity.

Sincerely,

Eric J. Klein, M.D.

ejk/jm

Russell & Bode Family Dentistry

Name [redacted]

2008 Caron Way SW
Olympia, WA 98502 PHONE: (360)742-3912

.: TREATMENT CASE

Crown #30

DATE	VISIT	TH	SURF	CODE	DESCRIPTION	FEE	PAT	PRI INS
09/25/2017	0	30		D2740	Crown-porcelain/ceramic substr	1020.00	510.00	510.00
09/25/2017	0	30		D2740.11	CROWN, PORCELAIN/CERAMIC PREP	0.00	0.00	0.00
09/25/2017	0	30		D2950	Core buildup, include any pins	174.00	87.00	87.00
					Visit 0 Totals:	1194.00	597.00	597.00

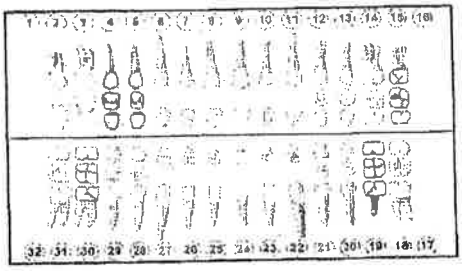
:: INSURANCE PROVIDER(S) ::

Primary: DELTA DENTAL OF WISCONSIN

Secondary:

:: TOTALS ::

Fee	Pat	Pri Ins
1194.00	597.00	597.00



:: FINANCIAL SUMMARY ::

Treatment Plan Total	1194.00
Estimated Deductible to be Applied	0.00
Estimated Insurance Payment	597.00
Estimated Patient's Portion	597.00
Fee Expiration Date	12/25/2017

Alternate Cases:

Case notes:

The following is an estimation of your recommended treatment. Estimated insurance benefits are listed above. This estimate is not a guarantee of payment from your insurance company. If you have any questions regarding the following information, please call the office.

Your patient balance is due the day services are provided in our office. Our primary mission at this office is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. For your convenience, we accept all major credit cards and Care Credit.

Payment for Crowns: 50% of your estimated portion is due at the first visit (to prep the tooth). The remaining 50% of your estimated portion is due at the second visit (the day we seat your permanent crown).

My signature confirms that I have been informed of my treatment needs and the cost involved. I am responsible for the payment of my portion at the time of service and any unpaid insurance balance after 60 days.

Signature_____ Date: _____

Estimate is good for 3 months

DATE: 09/25/2017