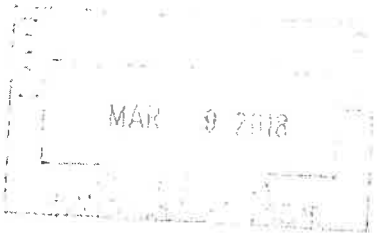
From: [redacted]
Subject:
Date:
To:
Cc: [redacted]

[redacted]lympia.wa.us



We received your 12/7/17 claim. We were not able to process it. There were two issues:

1. We need actual copies of your prescriptions in addition to payment receipts.
2. LEOFF policies only permit us to pay for one cleaning per year unless you have LEOFF board approval for more. You were paid on 5/9/17 for a dental cleaning. Here is the procedure to get approval from the board for multiple cleanings:

When he LEOFF Board met on February 9, 2015, one of the clarification items on the agenda was Interpretation of the Dental Reimbursement rule. The Board decided that if any LEOFF member has on ongoing dental cleanings (more than one a year) they would need to send Medical approval from a doctor, (not dentist) once every two years to continue being allowed cleanings more than once a year. The approval should state the reason the cleaning is needed more than once a year. (Such as, to reduce the chance of Heart disease, reduce chance of infections, or reduce Diabetes risk factors.) When you send us your verification we can process your 12/7/17 claim for $88.50 and you will be set for another two years. I have attached the necessary documents. Let me know if you have any questions. Thanks. Carl.

LEOFF Application for Payment of Services Case No: 04-18

Please Print Clearly & Legibly - Incomplete Form Will Be Returned

A) This Sect

Member Name [redacted] Retired: X

Member Telep

Member Addre [redacted]

Alternate Cont

Describe Your

Describe the Service/Treatment Requested: TEETH CLEANING TWICE A YEAR

Total Cost of Treatment/Service: $ 230.00

Amount Paid by Insurance/Medicare: $

Amount Requested from the Board $ 230.00

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: [redacted] Date 3-8-18

If signed by the alternate contact

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

Provider's Name: _____ Provider's Telephone: [redacted]

Clinic/Office Name: _____

Provider's Address: _____ 428

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

Hyperlipidemia - not duty related

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

Lifestyle management with medical management

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

Recommend biannual dental prophylaxis to reduce cardiovascular disease risk.

Provider's Signature [redacted] Date 3/5/18

Mail [redacted] 0) 709-2735 or
1967, Olympia WA 98507-1967

W:\LEOFF\FORMS\Application for Payment of Services 2012B.docx 4/20/2012

[redacted]

LEOFF 1
Claims Reimbursement Form (Police)

Name (Last, first)	[redacted]	Date claim submitted	3-12-18
Address		Check if new address, phone or email)	☒
City, State Zip			
Email		*HR internal use	

PLEASE COMPLETE AND SUBMIT THIS FORM WITH ALL CLAIM REIMBURSEMENTS

Date of Service (in date order oldest to newest)	Enter either (prescription, Medical, Dental or Vision)	Description	Qty	Total
10-11-17	DENTAL	PERIO MAINT.	1	$88.50
3-8-18	PRESCRIPTION	CRESTOR	1	15.00
		Total	2	$103.50

Submit claims for reimbursement via:

- Mail: Attn: HR, City of Olympia, 601 4th Ave. E., Olympia, WA 98501
- Email: humanresources@ci.olympia.wa.us
- Fax: 360-709-2735

RECEIVED
MAR 26 2018
CITY OF OLYMPIA
HUMAN RESOURCES DEPT

LEOFF 1 Disability policies and procedures, forms and detailed information about how to submit claims are posted on the city's website: LEOFF Disability Board Information

STATEMENT OF SERVICES RENDERED

[redacted]

PAGE NO.
1

BILLING DATE
10/11/2017

[redacted]

GUARANTOR NAME AND MAILING ADDRESS

[redacted]

PATIENT	TOOTH	SURF	DESCRIPTION	CHARGE	CREDIT
[redacted]			D0120:RECALL EXAM	52.00	
			D1999:ORAL CANCER SCREEN	0.00	
			D4910:PERIO MAINT	177.00	
			VISA/MC Payment -Thank You		-88.50

PRIOR BALANCE		CURRENT CREDITS		CURRENT CHARGES		NEW BALANCE		DENTAL INS. EST.		PLEASE PAY
0.00	-	88.50	+	229.00	=	140.50	-	140.50	=	0.00

PATIENT	DATE	TIME	REASON
[redacted]	Monday - December 4, 2017	2:00 pm	RC EXM, FL TREAT, PERIO MNT
	Monday - March 19, 2018	11:00 am	PERIO MNT, P.C.