LEOFF Application for Payment of Services Case No: 15-18

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: _____ Fire: X

Member Address: _____

Alternate Contact/Phone: _____ Email: _____

Describe Your Condition and Why It Is Duty Related: NOT DUTY RELATED. BROKEN TOOTH REQUIRED EXTRACTION - LEAVES LARGE GAP UPPER RIGHT SIDE - EFFECTS ABILITY TO CHEW.

Describe the Service/Treatment Requested: FILL SPACE WITH EITHER 1 OR 2 IMPLANTS AS NECESSARY

Total Cost of Treatment/Service: $ _____

Amount Paid by Insurance/Medicare: $ _____

Amount Requested from the Board $ _____

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: _____ Date: 11-15-18

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: Conley Payne Provider's Telephone: 360 352 4008

Clinic/Office Name: McDonald Dentistry

Provider's Address: 1205 Harrison Ave NW Olympia, WA 98502

Describe the Patient's Current Condition and State Whether It Is Duty Related: Not Duty Related Vertical Root fracture #5, extracted tooth - Non restorable, Now with edentulous space affecting chewing function & efficiency

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: Recommend Dental Implant placement in space to restore chewing function & efficiency. Patient will benefit from implant, allowing better food breakdown, digestion & continued healthy diet

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs: Removable Denture to replace 1 tooth → $2250 ; tx would work, not best tx

Provider's Signature: _____ Date: 11/15/18

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

Provider Brady C. McDonald, DDS

.: TREATMENT CASE

Treatment Plan

DATE	VISIT	TH	SURF	CODE	PROV	DESCRIPTION	FEE	PAT
11/15/2018	1			D0364	XX02	CT Capture, Lmtd View < 1 Jaw	75.00	75.00
11/15/2018	1	5		D6010	XX02	Implant	2189.00	2189.00
11/15/2018	1	5		D6056	XX02	Prefab abutment-incl placement	568.00	568.00
11/15/2018	1	5		D6058	XX02	Abutment supported porc/cer crn	1452.00	1452.00
11/15/2018	1	5		D9003	XX02	PREP/IMPRESSION	0.00	0.00
						Visit 1 Totals:	4284.00	4284.00

.: INSURANCE PROVIDER(S) ::	
Primary	Secondary

:: TOTALS ::			
Fee	Pat		
4284.00	4284.00		

:: FINANCIAL SUMMARY ::

Treatment Plan Total	4284.00
Estimated Deductible to be Applied	0.00
Estimated Insurance Payment	0.00
Estimated Patient's Portion	4284.00

:: DENTAL INSURANCE BENEFITS ::

		Patient		Family	
		Primary	Secondary	Primary	Secondary
Annual plan benefits		0.00	0.00	0.00	0.00
Paid Benefits YTD		0.00	0.00	0.00	0.00
Pending Insurance Est. YTD		0.00	0.00	0.00	0.00
Est. Benefits Remaining YTD		0.00	0.00	0.00	0.00
Benefits Expire		NA	NA		
Deductible Owed YTD	Standart	0.00	0.00	0.00	0.00
	Preventative	0.00	0.00	0.00	0.00
	Other	0.00	0.00	0.00	0.00

Alternate Cases:

mcdonaldfamilydental.com
1205 Harrison Ave NW
Olympia, WA 98502-5299
PHONE: (360)352-4008

REPORT DATE: 11/15/2018