LEOFF Application for Payment of Services Case No: 16-18

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/Phone: _____ Email: _____

Describe Your Condition and Why It Is Duty Related:

BROKEN TEETH / CROWN + BRIDGE

Describe the Service/Treatment Requested:

CROWNS AND BRIDGE

Total Cost of Treatment/Service: $ 5,475.00

Amount Paid by Insurance/Medicare: $ _____

Amount Requested from the Board $ 5,475.00

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: _____ Date: 11/20/18

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: DR. RASDAHL Provider's Telephone:

Clinic/Office Name:
1959 Commerce Center Circle

Provider's Address:
Prescott, AZ 86301

Describe the Patient's Current Condition and State Whether It Is Duty Related:
patient presents w/ missing and/or broken teeth upper left. Gross decay, mesial chack on old existing crown upper right/ Lower right

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary:
patient needs bridge to close gap to Chew and single Crowns only necessary treatment to save the single teeth

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:
patient could get an implant bridge at $10,000 + or a partial at $1,200+. patient will lose the teeth needing single crowns if they are not done

Provider's Signature: _____ Date: 11-26-18

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

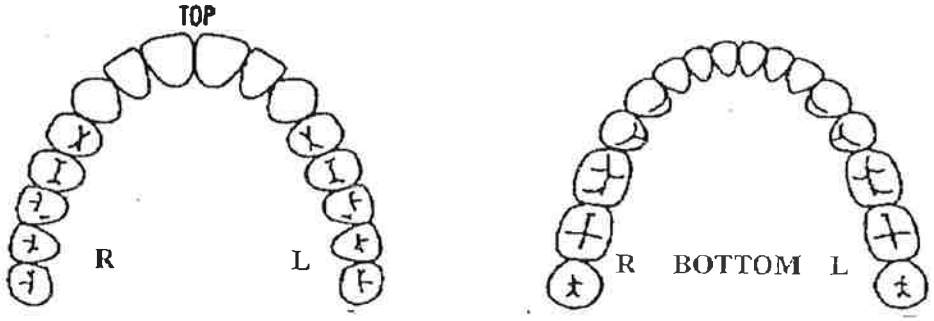
Proposed Treatment Plan

Keith L. Rosdahl, DDS
1959 Commerce Center Cir.
Prescott, AZ 86301
(928) 771-8166

Guarantor: Jodi MCBRIDE
Account Number: 0005794
Coverage: Single Insurance
Primary Carrier: MEDICO

Tuesday, November 20, 2018 **Patient:** **First Proposed:**

Th#	Surface	Code	Description	Std Fee	Charges	Ins. Share	Pt. Share
5		D2750	CROWN,PORCELAIN/HIGH NOBLE ME	1,095.00	1,095.00		1,095.00
13		D6790	ABUT-CAST HIGH NOBLE*	995.00	1,095.00		1,095.00
14		D6212	PONTIC - CAST NOBLE METAL*	995.00	1,095.00		1,095.00
15		D6790	ABUT-CAST HIGH NOBLE*	995.00	1,095.00		1,095.00
26		D2750	CROWN,PORCELAIN/HIGH NOBLE ME	1,095.00	1,095.00		1,095.00
			Totals:	5,175.00	**5,475.00**		**5,475.00**



Comments:

Primary Coverage: Maximum: 1,500.00 Deductible: 50.00 Preventive: 100% Basic: 80% Major: 50% CR/BR 50%
Dependent Limit: 1,500.00 Zero insurance share means treatment(s) not covered by insurance.

I REQUEST AND AUTHORIZE THE DENTIST OR QUALIFIED ASSIGNEE TO PERFORM THE DENTAL WORK LISTED ABOVE.

Patient or Guarantor's Signature _____ Date _____

Note: Insurance coverage in an estimate. Your actual indemnity may be less. Guarantor is responsible for all treatment not covered by the insurance carrier. The above treatment options are estimates of recommended treatments. Changes may occur due to additional diagnostic findings during treatment. In addition, fees are subject to change if work is not initiated and completed in a timely manner.