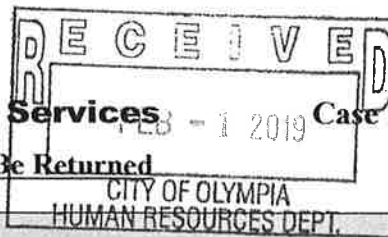


LEOFF Board Application for Payment of ServicesCase No: 04-19Please Print Clearly & Legibly - **Incomplete Form Will Be Returned****A) This Section To Be Completed by Member**Member Name: _____ Active: _____ Retired: ☒Member Telephone: _____ Police: _____ Fire: ☒

Member Address: _____

Alternate Contact: _____ Alternate Contact Telephone: _____

Describe Your Condition and Why It Is Duty Related: _____

Severe hearing loss due to sitting on top or directly below a Federal
Mi DecimaL Siren for 33 years with out having appropriate hearing protection.

Describe the Service/Treatment Requested: Hearing Aids purchase for both ears.Total Cost of Treatment/Service: \$ 2,499.98 from Costco & 3,726.27 from AVADAAmount Paid by Insurance/Medicare: \$ 0Amount Requested from the Board \$ 3,726.27 SEE ATTACHED INFO.

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: JAN 31, 2019

() 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

(attach additional pages as needed)

Provider's Name: _____ Provider's Telephone: _____

Clinic/Office Name: See Attached Info from Costco AND AVADA

Provider's Address: _____

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

info from the hearing aid providers. This claim is not covered by
Insurance.

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

Attached Info provided.

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

See Attached information.

Provider's Signature: See Attached Information Date: JAN 31 - 2019

Fax Completed Form to: (360) 709-2735 or mail to: City Of Olympia HR Dept, PO Box 1967, Olympia WA 98507-1967

04-19
Quote

111867551848

PRINT NAME OF USER _____ MEMBERSHIP NO. _____

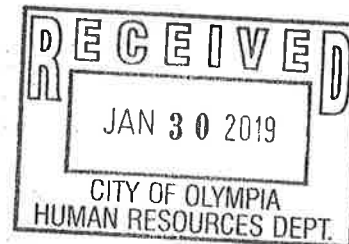
ADDRESS _____

TELEPHONE NO. _____

PRINT NAME OF BUYER (INDICATE IF BUYER IS THE SAME AS USER) _____ MEMBERSHIP NO. _____

ADDRESS _____

TELEPHONE NO. _____



	Item #	Make/Model/Description	Serial #	Battery Size	Price
Right Ear	1283765	Resound RIC		312	\$ 1249.99
Left Ear	1283765	Resound RIC			\$ 1249.99
Ear Mold/Components	Right Item # _____	\$ _____	Left Item # _____	\$ _____	\$ _____
Accessories	Item # _____				\$ _____
Services/Other					\$ _____
					Tax (if applicable) \$ _____
					TOTAL \$ 2499.98

☐ Check ☐ Cash ☐ Credit Card ☐ Debit

Manufacturer warranty periods are noted below:

Hearing Aid _____ Months	Hearing Aid Damage _____ Months	Hearing Aid Loss _____ Months
Ear Mold _____ Months	Hearing Aid Components _____ Months	Accessories _____ Months
Other: _____		

180-DAY TRIAL PERIOD: During the 180-day trial period following the Dispensing Date, you may return the hearing aid, component, ear mold, and accessories for any reason to receive a full refund provided you return the item to the Costco Hearing Aid Center in the same condition as when purchased, ordinary wear and tear excluded. The 180-day trial period shall commence from the date the hearing aid is originally delivered to you or the date this purchase agreement is delivered to you, whichever is later. The 180-day trial period shall be tolled for any period during which the hearing aid specialist or audiologist has possession or control of the hearing aid after its original delivery. No cancellation fee will be assessed by the Costco Hearing Aid Center.

LAST DAY TO RETURN ITEMS FOR FULL REFUND: _____

MANUFACTURER WARRANTY POLICY: Beginning on the Dispensing Date, as identified below, the hearing aid, components, ear mold and accessories you purchased are warranted by the manufacturer to be free from all defects in materials and workmanship, and the manufacturer agrees to make all necessary repairs or, at the manufacturer's option, provide a replacement without charge to the buyer during the warranty periods noted above.

ONE-TIME REPLACEMENT POLICY FOR LOSS OR DAMAGE: Beginning on the Dispensing Date, if the hearing aid you purchased is warranted for damage (as noted above) and is damaged beyond repair or is warranted for loss (as noted above) and is lost or stolen, the manufacturer will provide a one-time replacement with a comparable model for the same ear, at no additional charge. You will receive only one replacement of your hearing aid whether that replacement is provided under the damage policy or the loss policy. The manufacturer's warranty policy will continue to apply to the replacement hearing aid for the remainder of the manufacturer's warranty period indicated above. If you find the lost or stolen hearing aid after replacement, it becomes the property of the manufacturer and must be returned to the Costco Hearing Aid Center. **Please note that the hearing aid replaced under the Loss or Damage Policy cannot be returned for a refund.**

Buyer's Initials: _____

98512

360-357-8470

Last Name

First Name

Date of Birth

Address 1

x

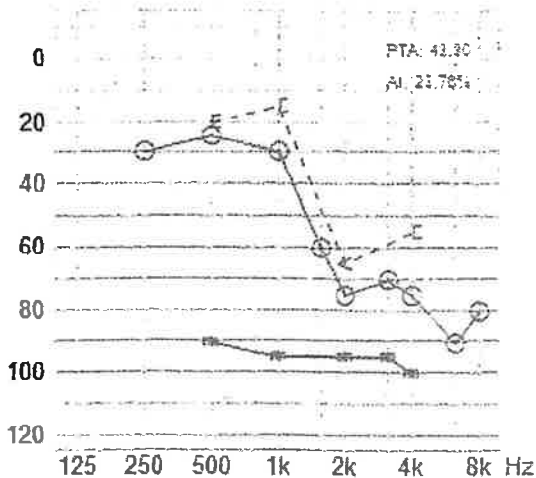
ZIP Code, City

99999 x

Home Phone

Right

dB



Tone Audiometry

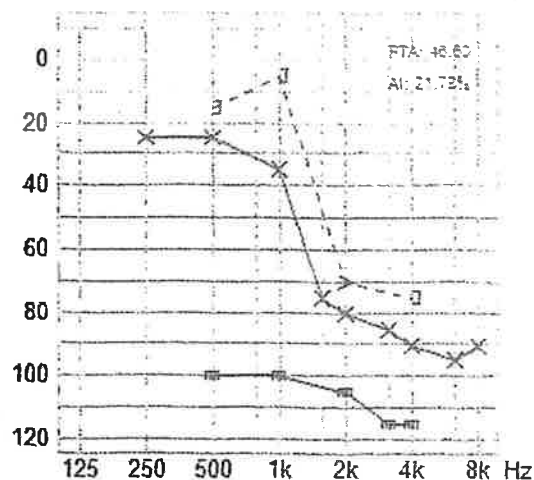
THR BC
Left:BC, Mask:AC
Right:BC, Mask:AC

UCL Insert
Left AC
Right AC

THR Insert
Left AC
Right AC

Left

dB



Masking

[illegible]

AC

BC

Masking

			50		55				90	

Right						Binaural/Dichotic						Left					
	AC	AC2	BC	SF	Aided		AC	AC2	BC	SF	Aided		AC	AC2	BC	SF	Aided
SRT	35					dB						dB	40				
Mask						dB						dB					
SAT						dB						dB					
Mask						dB						dB					
WRS1	70					dB	70					dB	70				
Mask						dB	70					dB					
Score	47					%	41					%	20				
WRS2						dB	75					dB					
Mask						dB	75					dB					
Score						%	93					%					
WRS3						dB						dB					
Mask						dB						dB					
Score						%						%					
MCL	70					dB						dB	70				
UCL	90					dB						dB	90				

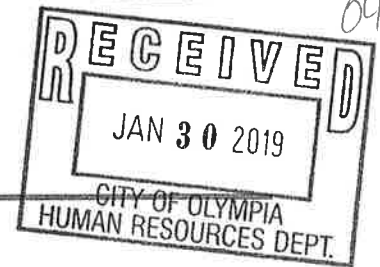
Date of Record:

1/27/2019 11:26:16 AM

WALSH
60845024



2600 Martin Way E Suite A • Olympia, WA 98506
Tel: 360-943-8920 • e-mail: pmag@avada.com



January 14, 2019

LEOFF 1 Board

RE:

This letter is a request for hearing instruments for Mr. Following is an itemized cost list for the hearing instruments. A Three-year warranty for repair is included. If you have any questions feel free to contact me at 360-943-8920.

V5261 Oticon Opn 1 miniRITE \$3726.27
With ConnectClip

Sincerely,

A handwritten signature in black ink, appearing to read "Paul Magnusson", written over a horizontal line.

Paul Magnusson, BC-HIS
Avada Hearing Care