LEOFF Application for Payment of Services Case No: 06-19

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section to Be Completed by LEOFF 1 Member

Member Name: _____ Active: _____ Retired: X

Member Telephone: _____ Police: X Fire: _____

Member Address: _____

Alternate Contact/Phone: _____ Email: _____

Describe Your Condition and Why It Is Duty Related: N/A

Describe the Service/Treatment Requested: REMOVAL OF FOUR BROKEN - DAMAGED LOWER FRONT TEETH. INSTALLATION OF BRIDGE

Total Cost of Treatment/Service: $ 8050.00 7245.00

Amount Paid by Insurance/Medicare: $ N/A

Amount Requested from the Board $ 8050.00 7245.00

LEOFF member-Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the

Member Signature: _____ Date: 6/26/19

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. THINH HO DDS Provider's Telephone: 360-943-4777

Clinic/Office Name: OLYMPIA DENTAL GROUP

Provider's Address: 6050 PACIFIC AVE. SE, LACEY, WA 98503

Describe the Patient's Current Condition and State Whether It Is Duty Related: NOT DUTY RELATED SEE ATTACHED LETTER

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

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

4 extractions, bone grafts, implants + implant crowns = $15,780.00

Outcome good, possible implant failure in future.

Provider's Signature: _____ Date: 6/26/2019

Fax completed form to: (360) 709-2735 or

Mail to: Attn: HR, City Hall, PO Box 1967, Olympia WA 98507-1967

RECEIVED
JUL 01 2019
CITY OF OLYMPIA
HUMAN RESOURCES DEPT.

06-19

LEOFF 1
Claims Reimbursement Form

Name (Last, first)		Vendor #		Date claim submitted	6/28/19
		Bars #			
Address		Primary phone #	see below	Check if new (address, phone or email)	☑
City, State Zip		Cell #			
Email					

PLEASE COMPLETE AND SUBMIT THIS FORM WITH ALL CLAIM REIMBURSEMENTS

Date of Service (in date order oldest to newest)	Select either (prescription, Medical, Dental or Vision)	Description	Qty	Total
3-20-19 TO 6-5-19	DENTAL SURGERY	REMOVAL OF BROKEN TEETH INSTALLATION OF BRIDGE		~~8050.00~~
				7245.00
		Total	0	~~8050~~ 7245.00

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

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

Olympia DENTAL GROUP
your smile... our priority

06-19

June 6, 2019

To whom it may concern,

This letter is regarding the treatment for came in for an exam on 3/2/2019. He had bitten down hard on a peach pit and fractured his lower front teeth. Upon review of the x-rays taken, #23-26 had severe bone loss and were non restorable with Cl III mobility. I recommended extracting those teeth & placing a 6 unit bridge from #22-27. This is medically necessary so the patient can eat and chew successfully.

Please don't hesitate to call if you have any questions.

Thank you,

Thinh Ho DDS

6050 Pacific Ave SE • Lacey, WA 98503 • Phone (360) 943-4777 • Fax (360) 753-8974

Olympia Dental Group
Dr. Thinh Ho
6050 Pacific Ave SE
Lacey, WA 98503
(360)943-4777 x

06-19

PATIENT TRANSACTIONS

From 04/22/19 to 05/20/19

Account: (
Patient: (

Date	Patient	ID	Code	D$	Dr	*	T	Surf	Description	Prod.	Charges	Chg Adj	Payment	Pay Adj	Balance
									Previous Balance						0.00
04/22/19		439201	7140	7	7	A	23		Extraction, Erupted Tth or Expo:	200.00					200.00
04/22/19		439201	7140	7	7	A	24		Extraction, Erupted Tth or Expo:	200.00					400.00
04/22/19		439201	7140	7	7	A	25		Extraction, Erupted Tth or Expo:	200.00					600.00
04/22/19		439201	7140	7	7	A	26		Extraction, Erupted Tth or Expo:	200.00					800.00
04/22/19		439201	51	7	7	A			Professional Courtesy Credit			-80.00			720.00
04/22/19		439201	12	7		A			Visa Card Payment - Thank You				720.00		0.00
05/20/19		439201	6740	7	7	A	22		Crown - Porcelain/Ceramic	1100.00					1100.00
05/20/19		439201	6245	7	7	A	23		Pontic - Porcelain/Ceramic	1100.00					2200.00
05/20/19		439201	6245	7	7	A	24		Pontic - Porcelain/Ceramic	1100.00					3300.00
05/20/19		439201	6245	7	7	A	25		Pontic - Porcelain/Ceramic	1100.00					4400.00
05/20/19		439201	6245	7	7	A	26		Pontic - Porcelain/Ceramic	1100.00					5500.00
05/20/19		439201	6740	7	7	A	27		Crown - Porcelain/Ceramic	1100.00					6600.00
05/20/19		439201	2950	7	7	A	22		Core Buildup, Including Any Pir	325.00					6925.00
05/20/19		439201	2950	7	7	A	27		Core Buildup, Including Any Pir	325.00					7250.00
05/20/19		439201	51	7	7	A			Professional Courtesy Credit			-725.00			6525.00
05/20/19		439201	12	7		A			Visa Card Payment - Thank You				6525.00		0.00
									PATIENT TOTALS	**8050.00**	**0.00**	**-805.00**	**7245.00**	**0.00**	**0.00**

Paid 5/20/19 TH

Total Tax on productions and charges: $0.00

****The above totals reflect only those transactions during the dates selected.**

The full account balance is: $0.00.
The full patient balance is: $0.00.

Account BP Balance: $0.00