LEOFF Board Application for Payment of Services Case No: 13-19

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: Alternate Contact Telephone:

Describe Your Condition and Why It Is Duty Related: Leg Swelling due to Vein & Artery Blockage in Legs – especially After 3 knee Surgeries on Same Leg from Fire Service

Describe the Service/Treatment Requested: Had to Wear Compression Stockings & needed tool to Assist in placing on Leg. Medicare requires these but does Not Cover Cost

Total Cost of Treatment/Service: $ 87.00

Amount Paid by Insurance/Medicare: $ None

Amount Requested from the Board $ 87.00

at years of age & me, his wife, at cannot get the compression stocking on w/o the $37 tool.

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: 11/7/2019

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: Dr. Hassan Makki Provider's Telephone: 480.374.7354

Clinic/Office Name: CIC - Comprehensive Integrated Care

Provider's Address: 6301 S. McClintock Dr Suite 115 Tempe AZ 85283

Describe the Patient's Current Condition and State Whether It Is Duty Related. venous insufficiency, peripheral arterial Disease, leg swelling

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: patient has both venous and arterial disease, will continue w/ thigh high compression and monitor for any worsening symptoms. If symptoms

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs: persist/worsen will consider vein ablation/angiography

Provider's Signature: Date: 11/19/19

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

LEOFF 1
Claims Reimbursement Form (Fire)

Name (Last, first)		*Vendor #		Date claim submitted	11/5/2019
		*Bars #	014-1714-530-22.02		
Address		Primary phone #		Check if new (address, phone or email)	☐
City, State Zip		Cell #			
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
11/4/2019	Medical	Comprehensive Compressional Stockings Prescribed for Vein Problems in both Legs	1	$50.00
11/4/2019	Medical	Large Butler Needed to Put Thigh High Compression Stockings on	1	$37.00
			Total	$87.00

RECEIVED
NOV 05 2019
CITY OF OLYMPIA
HUMAN RESOURCES DEPT.

Submit claims for reimbursement via:

Mail: Attn: HR, City of Olympia, PO Box 1967, Olympia, WA 985[illegible]
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 Board Information

Payment Receipt

PAYMENT APPROVED
Approval Code 00951C
Reference Number DVORSQDR27

Payment Information

Patient Name	Amount	Payment Method	Card Number	Payment Date
	$37.00	Credit/Debit Card	VISA - 2924	11/04/2019 05:30:30 PM (EST)

Patient ID	Plan ID	Txn. Type	Notes
		Other Payment	Large Butler

Claim Number	Encounter ID	Date of Service
		11/04/2019

Signature

Payment Receipt Generated On: 11/04/2019

Payment Receipt

PAYMENT APPROVED
Approval Code 06630C
Reference Number H2VMJRULGT

Payment Information

Patient Name	Amount	Payment Method	Card Number	Payment Date
	$50.00	Credit/Debit Card	VISA - 2924	11/04/2019 01:45:53 PM (EST)

Patient ID	Plan ID	Txn. Type	Notes
		Other Payment	two legs hose $50 20/30

Claim Number	Encounter ID	Date of Service
		11/04/2019

Signature

A. Notifier: CiC VEIN CENTERS

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. hosiery below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. hose below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
20-30 Thigh High Compression Stockings	Not covered by Medicare	$50

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. hose listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☑ **OPTION 2.** I want the D. hose listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
	11/3/2019

6301 S. McClintock Drive, Suite 115
Tempe, AZ 85283
480-775-7460

LEOFF Board Application for Payment of Services Case No: ____________

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Member Name:	ne Active: ________	Retired: ✓	
Member Telephone:	Police: ________	Fire: ✓	
Member Address:			
Alternate Contact: Faith Missildine	Alternate Contact Telephone:		

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Member Signature: ______ Date: 11/7/2019

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B) This Section To Be Completed by Member's Attending Health Care Provider
(attach additional pages as needed)

Provider's Name: Provider's Telephone:

SIGVARIS **Prescription Pad**

Patient: Date: 11/4/19

Diagnosis: venous insuffiency Number of Refills

Compression (mmHg)	Symptoms/ Indications
☐ 15–20	Tired, achy legs • Occupational or evening edema • Leg discomfort from long hours of standing or sitting • Prophylaxis of varicosities & swelling during pregnancy Prophylaxis for legs predisposed to risk • Reduce swelling during travel • Prophylaxis of DVT during travel
☐ 18–25	Diabetics who experience edema (see Cautions below)
☒ 20–30	Heavy, fatigued, aching legs • Mild edema in lower extremities • Mild varicosities with minimal edema • Mild varicosities during pregnancy • Minimal edema upper extremities Post-procedure of small veins – Prevention or management of DVT
☐ 30–40	Moderate varicosities with mild to moderate edema (also during pregnancy Post-procedure of larger veins to maintain treatment success • CEAP C3 (edema), C4 (skin changes without ulceration), C5 (skin changes with healed ulceration), C6 (skin changes with active ulcerations) • Management and treatment of DVT or Post-Thrombotic Syndrome Superficial phlebitis • Lymphedema after decongestant therapy to maintain reduction Orthostatic / postural hypotension • Post-fracture, post-traumatic edema
☐ 40–50 or higher	Irreversible lymphedema (lifelong compression) • Severe Post-Thrombotic Syndrome Severe varicosities and/or edema Note: Stockings with the indications of 30mmHg or higher should only be prescribed by medical specialists
Contra-indications	Arterial insufficiency, intermittent claudication, ischemia Uncontrolled congestive heart failure
Cautions	Skin sensitivities or allergies • Advanced neuropathy indicating sensory loss in leg or foot Diabetes with advanced arterial compromise • Confinement to bed or non-ambulatory use unless otherwise prescribed by the physician • Eczema, hypodermatitis, dermasclerosis, dermatitis (following treatment)

Style ☐ Closed Toe ☐ Open Toe ☐ Patient Choice Short-stretch wraps

☐ Calf ☐ Grip-top ☒ Thigh ☐ Pantyhose ☐ L ☐ R Thigh w/ Waist ☐ Maternity/ Plus Sizes ☐ COMPREFLEX LITE ☐ COMPREFLEX NF ☐ COMPREFLEX BK (20–50mmHg only)

☐ ARMSLEEVE with Gauntlet ☐ ARMSLEEVE without Gauntlet
☐ Latex Free Gloves ☐ SIGVARIS Doff N' Donner (Donning Device)
☐ Rubber Gloves ☐ S.O.S. (Slip On SIGVARIS Donning Device)
☐ Cotton Underliner ☐ Cornu-Thenard Extensor (Donning Device)

Physician Name: Dr. Hassan Makki

Physician Signature: X [signature]

License Number: Phone: 4803147354

Nov 10 19 10:18a p.2