LEOFF Application for Payment of Services

Case No: 20-3

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section to Be Completed by LEOFF 1 Member

Member Name: _____ Active: _____ Retired: ✓

Member Telephone: _____ Police: _____ Fire: _____

Member Address: _____

Alternate Contact/Phone: _____ Email: _____

Describe Your Condition and Why It Is Duty Related: _____

Describe the Service/Treatment Requested: REMOVAL of 4 TEETH
NEW UPPER and LOWER PLATE

Total Cost of Treatment/Service: $ 3743.00

Amount Paid by Insurance/Medicare: $ NONE

Amount Requested from the Board $ 2600.00

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

Member Signature: _____ Date: _____

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: Mark Bird Provider's Telephone: 360 438-8254

Clinic/Office Name: Olympic Dental and Denture

Provider's Address: 4408 Pacific AVE SE Lacey, WA 98503

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

WNL

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

NEW DENTURES (UPPER/LOWER) RECOMMENDED.
IMPRESSIONS TAKEN. NEXT VISIT SCHEDULED.

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

Provider's Signature: _____ L.D. Date: 11/19/19

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

LEOFF Application for Payment of Services Case No: 20-3

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: _____ Fire: _____

Member Address: _____

Alternate Contact/Phone: _____ Email: _____

Describe Your Condition and Why It Is Duty Related: _____

Describe the Service/Treatment Requested: Removal of 4 Rotten Teeth, New Set of Upper and Lower Plates (Fixed Teeth)

Total Cost of Treatment/Service: $ 3743.00

Amount Paid by Insurance/Medicare: $ N/A

Amount Requested from the Board $ 2600.00

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

Member Signature: _____ Date: _____

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: Yoo Jung Chung, DMD Provider's Telephone: 360 438-8299

Clinic/Office Name: Olympic Dental + Denture

Provider's Address: 4408 Pacific Ave SE, Lacey WA 98503

Describe the Patient's Current Condition and State Whether It Is Duty Related: Patient has 4 remaining teeth on lower that are not salvagable. Not duty related

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: Recommend extracting remaining teeth and fitting with a new set of dentures for the health of mouth and aid in eating.

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs: There is not an alternative plan.

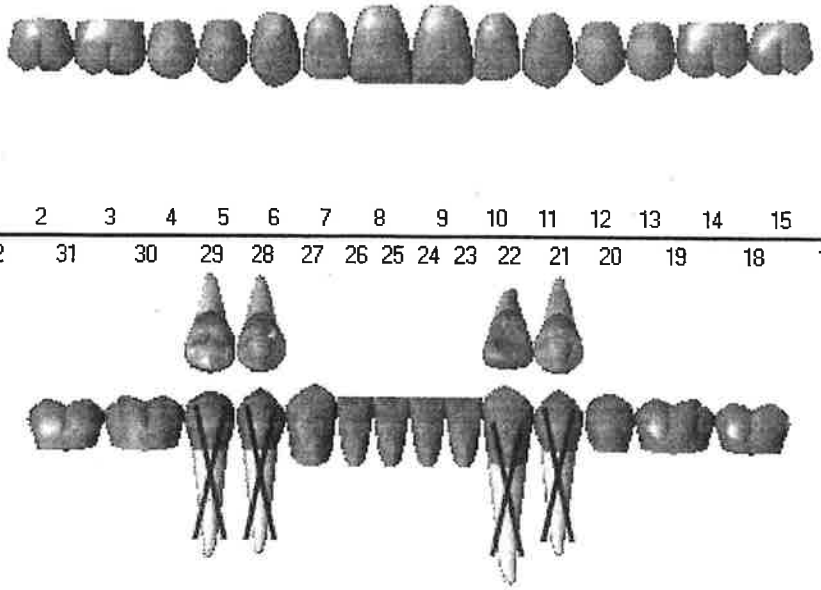
Provider's Signature: _____ Date: 12/3/19

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

Active Treatment Plan

Olympic Dental and Denture Center
(360)438-8299

11/12/2019



Existing Complete Referred Out Treatment Planned

Done	Priority	Tth	Surf	Code	Sub	Description	Fee
	1			D0150		comprehensive oral evaluation - new or established patient	49.00
	1			D0330		panoramic radiographic image	0.00
	1		U	D5110		Upper Denture	980.00
	1		L	D5140		Lower Immediate Denture	1370.00
						Subtotal	**2399.00**
	2	21		D7210		Surgical Extraction	226.00
	2	22		D7210		Surgical Extraction	226.00
	2	28		D7210		Surgical Extraction	226.00
	2	29		D7210		Surgical Extraction	226.00
						Subtotal	**904.00**
	4		L	D5751		reline complete mandibular denture (laboratory)	440.00
						Subtotal	**440.00**
						Total	**3743.00**

If you have dental insurance, please be aware that THIS IS AN ESTIMATE ONLY. Coverage may be different if your deductible has not been met, annual maximum has been met, or if your coverage table is lower than average.

Olympic Dental and Denture Center
4408 Pacific Ave SE
Lacey, WA 98503-1119
(360)438-8299

STATEMENT

12/23/2019
Account Number 33518

Total:	$0.00
-Ins Estimate:	$0.00
=Balance:	**$0.00**

Date	Patient	Code	Tooth	Description	Charges	Credits	Balance
				Balance Forward			-2,350.00
12/23/2019	Dale	D5110		U- Upper Denture	980.00		-1,370.00
12/23/2019	Dale	D5140		L- Lower Immediate Denture	1,370.00		0.00
12/23/2019	Dale	D7140	21	Simple ext	130.00		130.00
12/23/2019	Dale	D7210	22	Surgical Extraction	226.00		356.00
12/23/2019	Dale	D7210	28	Surgical Extraction	226.00		582.00
12/23/2019	Dale	D7140	29	Simple ext	130.00		712.00
12/23/2019	Dale	Pay		Credit Card $712.00		712.00	0.00

* Staff approved + reimbursed 1/27/2020