LEOFF Application for Payment of Services

Please Print Clearly & Legibly - Incomplete Form Will Be Returned

Member Name:	Active:	Retired: 1
Member Telephone:	Police:	Fire
Member Address: Alternate Contact/Phone:	Tonoy.	I nc.
Alternate Contact/Phone:	Email:	1 1 1 1 -
Describe Your Condition and Why It Is Duty R	Related:	
Describe the Service/Treatment Requested:	REMOUNT OF 4	TEATH
Total Cost of Treatment/Service: \$ Amount Paid by Insurance/Medicare: \$ Amount Requested from the Board \$		
LEOFF member-Please attach the Effrom your insurance provider(s)	xplanation of Benefi	ts statement(s)
	and/or Medicale WII	ich indicates the
Member Signature: Please attach a copy/of the Po	D wer of Attorney if signed by the alt	ate: _ ernate contact.
Member Signature: Please attach a copy/of the Po	D wer of Attorney if signed by the altorney is Attended by Member's Attended	ate: _ emate contact. ing Health Care
Member Signature: Please attach a copy/of the Po	D wer of Attorney if signed by the altorney is Attended by Member's Attended	ate: _ ernate contact. ing Health Care
Please attach a copy/of the Portage B) This Section To Be Completed Provider's Name: Mark Bird Clinic/Office Name: Output	wer of Attorney if signed by the alt by Member's Attend Provider's Telep	ate: _ emate contact. ing Health Care hone: 360 438-829
Please attach a copy/of the Portion To Be Completed Provider's Name: Clinic/Office Name: Provider's Address: 4408 Pacific Address:	D wer of Attorney if signed by the alt by Member's Attend Provider's Telep Add and Menture DE SE Lacey L	ate: _ernate contact. ing Health Care hone: 360 438-829
Please attach a copy/of the Portion To Be Completed Provider's Name: Mark Bird Clinic/Office Name: Dympic Deprovider's Address: 4408 Pacific Address:	D wer of Attorney if signed by the alt by Member's Attend Provider's Telep Add and Menture DE SE Lacey L	ate: _ernate contact. ing Health Care hone: 360 438-8299
Please attach a copy/of the Portion To Be Completed Provider's Name: Mark Bird Clinic/Office Name: Dympic Deprovider's Address: 4408 Pacific Address:	D wer of Attorney if signed by the alt by Member's Attend Provider's Telep Add and Menture DE SE Lacey L	ate: _ernate contact. ing Health Care hone: 360 438-8299
Please attach a copy/of the Portion To Be Completed Provider's Name: Wark Bird Clinic/Office Name: Dympic Describe the Patient's Current Condition and St	wer of Attorney if signed by the alt I by Member's Attendary Provider's Telep Attack Cond Menture DE DE Lacey Late That Whether It Is Duty Relate	ate: _ernate contact. ing Health Care hone: 360 438-8299 sA 98503 d:
Please attach a copy of the Portion To Be Completed Provider's Name: Clinic/Office Name: Provider's Address: 4408 Pacific Address:	Provider's Telepoted and Why It Is Medically Nece	ate: _ernate contact. ing Health Care hone: 360 438-8299 sA 98503 d:
Please attach a copy/of the Por	wer of Attorney if signed by the alto by Member's Attendary Teleportal and Menture De De Lacey, Late Whether It Is Duty Relate and Why It Is Medically Nece Den Luwtr	ate: _emate contact. ing Health Care hone: 360 438-8299 SA 98503 d:
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Case No: 20-3

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: <u>20-3</u>

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section to Be Comple	eted by LEOFF 1 Member	
Member Name:	Active:	Retired:
Member Telephone:	Police:	Fire:
Member Address:		2
Alternate Contact/Phone:	Email:	
Describe Your Condition and Why It Is Dut		
Describe the Service/Treatment Requested: NEW SET OF MIPPIER A	Removal of y	Rotten Trakt tes Citasles Te
Total Cost of Treatment/Service:	\$ 3743,00	
Amount Paid by Insurance/Medicare:	\$ NONR	
Amount Requested from the Board	\$ 2600 = 00	
LEOFF member-Please attach the from your insurance provider	e Explanation of Benefi (s) and/or Medicare wh	ts statement(s) ich indicates the
Member Signature:	D	ata.
Please attach a copy of the	e Power of Attorney if signed by the alto	ernate contact.
B) This Section To Be Complet		
Provider's Name: You Jung Chang	Provider's Telep	hone: 360 438-829
Clinic/Office Name: Durapic New	rted & Senture	1.
Provider's Address: 4408 Pacific	AVE SE, LOCKY	
Describe the Patient's Current Condition and	d State Whether It Is Duty Relate	d: Peitient has
4 remaining teeth on like	ser that we not	Suveable.
NOT any related		
Describe Your Recommended Treatment Pla	an and Why It Is Medically Nece	ssary: Recommend
extracting remaining teet	h and titting with	4 new Set of
vertures fir the health	it mouth and aid	in Phtina
Please Describe Any Reasonable Alternative	e Treatment Plans. Include Expec	ted Outcome & Costs:
There is not an alternat	ive plen.	
Provider's Signature:	D-4	12/2/12
	Date:	12/3/19

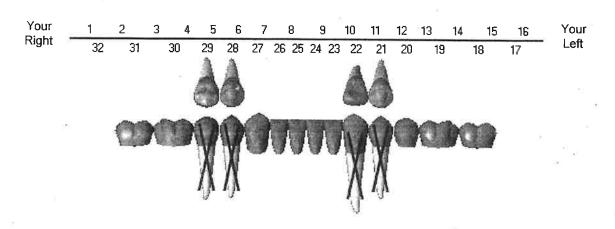
Fax completed form to: (360) 709-2735 or Mail to: Attn: HR, City Hall, PO Box 1967, Olympia WA 98507-1967

Active Treatment Plan

Olympic Dental and Denture Center (360)438-8299

11/12/2019





	Existing		Complete		Referred Out Treatment Plann		ed
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
367						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 Tooti		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	130.00	712.00	

* Staff approved + rimbursed 1/27/2020