to Debbie Stefano
Fax - 360-709-2735
360-956-3419

LEOFF Board Application for Payment of Services Case No: 20-11

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: Approx 40 years ago I fell off fire engine & hit Concrete floor - At that time two front teeth had to be replaced - Now one broke off at gum line.

Describe the Service/Treatment Requested:
front tooth needs to be replaced

Total Cost of Treatment/Service: $ Amount Attached

Amount Paid by Insurance/Medicare: $ – – –

Amount Requested from the Board $ 6,008.00 - Total Cost

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: 9/9/2020

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: ______

Provider's Address: ______

Describe the Patient's Current Condition and State Whether It Is Duty Related:
Tooth #8 fractured at the gumline. Tooth is non-restorable.

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: The root requires an extraction and needs to be replaced with an implant to restore patients aesthetics and function.

3013 - Dentist
2995 - oral surgeon

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:
None
$2995.00

Dentist
Oral Surgeon

Provider's Signature: [signature] Date: 9/9/2020

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

Nish Shah DMD, MD

Revised 12/27/07

Location: \Calvin Personnel Forms\

STATEMENT OF SERVICES RENDERED

Sierra Family Dentistry
600 S Dobson Rd, Ste. 8 Bldg B
Chandler, AZ 85224-5674

(480)899-3425

CHART NO	PAGE NO
000082	1

BILLING DATE: 09/09/2020

GUARANTOR NAME AND MAILING ADDRESS

PATIENT	TOOTH	SURF	DESCRIPTION	CHARGE	CREDIT
			Limited oral evaluation	44.00	
			Interim partial denture (maxil)	399.00	
			Usage of Scanner w/o Simulation	0.00	
	8		Occlusal guard- hard, full arch	570.00	
	8		Custom abutment-incl placement	950.00	
			Abutment supported porc/cer crn	1050.00	
			Visa/MC/Discover - Thank you		-3013.00

SIERRA FAMILY DENTISTR
600 S DOBSON RD #B-8
CHANDLER, AZ 85224
09/09/2020 09:26:07
CREDIT CARD
VISA SALE
Card # XXXXXXXXXXXX2924
SEQ #: 2
Batch #: 1276
INVOICE 2
Approval Code: 08227C
Entry Method: Swipe
Mode: Online
SALE AMOUNT $2713.00
CUSTOMER COPY

SIERRA FAMILY DENTISTR
600 S DOBSON RD #B-8
CHANDLER, AZ 85224
09/09/2020 09:25:42
CREDIT CARD
MC SALE
Card # XXXXXXXXXXXX7287
SEQ #: 1
Batch #: 1276
INVOICE 1
Approval Code: 009959
Entry Method: Swipe
Mode: Online
SALE AMOUNT $300.00
CUSTOMER COPY

PRIOR BALANCE		CURRENT CREDITS		CURRENT CHARGES		NEW BALANCE		DENTAL INSURANCE		PLEASE PAY
0.00	-	3013.00	+	3013.00	=	0.00	-	0.00	=	0.00

PAYMENT	DATE	AMOUNT	PATIENT/INSURANCE

There will be a charge of $50 for appointments cancelled or broken without a 24 hour advanced notice. VISIT OUR WEBSITE @ WWW.CHANDLERSMILES.COM

 LWLK 1

ATTENDING DOCTOR'S STATEMENT

DATE: 09/09/2020

PATIENT INFORMATION

PATIENT NAME:

BIRTHDAY: (87)

SOC. SEC. NUMBER:

CHART NUMBER: 000082

RELATION TO SUBSCRIBER:

PROVIDER INFORMATION

NAME OF DENTIST: Eliya R Zaidi, DMD
Sierra Family Dentistry
600 S Dobson Rd, Ste. 8 Bldg B
Chandler, AZ 85224-5674

(480)899-3425

NPI: 1598726721

TIN: 200690674

LICENSE NUMBER: D05462

INSURANCE INFORMATION

CARRIER:

GROUP NUMBER:

EMPLOYER:

SUBSCRIBER:

Subscriber ID: Subscriber Birthday:

Remarks for unusual services:

DATE	TOOTH	SURF	CODE	PROCEDURE	AMOUNT
09/09/2020			D0140	Limited oral evaluation	44.00
09/09/2020			D5820	Interim partial denture (maxil)	399.00
09/09/2020			D9559	Usage of Scanner w/o Simulation	0.00
09/09/2020			D9944	Occlusal guard- hard, full arch	570.00
09/09/2020	8		D6057	Custom abutment-incl placement	950.00
09/09/2020	8		D6058	Abutment supported porc/cer crn	1050.00
				TOTAL:	3013.00

Pd in full

There will be a charge of $50 for appointments cancelled or broken without a 24 hour advanced notice. VISIT OUR WEBSITE @ WWW.CHANDLERSMILES.COM

Eliya R Zaidi, DMD
SIGNED (TREATING DENTIST)

09/09/2020
DATE

Sierra Family Dentistry

Name

Chart Number 000082

.: TREATMENT CASE

Treatment Plan

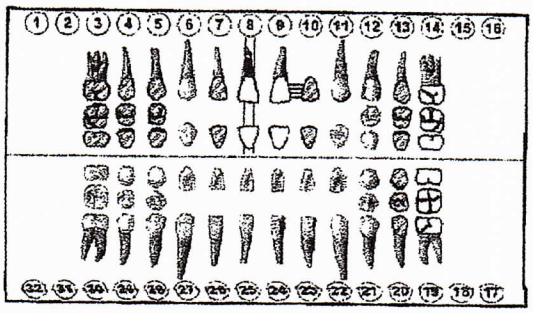
DATE	VISIT	TOOTH	SURF	CODE	PROV	DESCRIPTION	FEE	PATIENT	Office
09/09/2020	1			D5820	EZ01	Interim partial denture (maxil)	399.00	399.00	876.00
09/09/2020	1			D9559	EZ01	Usage of Scanner w/o Simulation	0.00	0.00	0.00
09/09/2020	1			D9944	EZ01	Occlusal guard- hard, full arch	570.00	570.00	712.00
09/09/2020	1	8		D6057	EZ01	Custom abutment-incl placement	950.00	950.00	1455.00
09/09/2020	1	8		D6058	EZ01	Abutment supported porc/cer crn	1050.00	1050.00	1682.00
						Visit 1 Totals:	2969.00	2969.00	4725.00

:: INSURANCE PROVIDER(S) ::

Primary Secondary

:: TOTALS ::

Fee	Patient		Office
2969.00	2969.00		4725.00



:: FINANCIAL SUMMARY ::

Treatment Plan Total	2969.00
Estimated Deductible to be Applied	0.00
Estimated Insurance Payment	0.00
Estimated Patient's Portion	2969.00
Patient Balance	0.00
Family Balance	0.00

:: DENTAL INSURANCE BENEFITS ::

		Patient		Family	
		Primary	Secondary	Primary	Secondary
Annual plan benefits		0.00	0.00	0.00	0.00
Paid Benefits YTD		0.00	0.00	0.00	0.00
Pending Insurance Estimate YTD		0.00	0.00	0.00	0.00
~~Estimated Benefits Remaining YTD~~		0.00	0.00	0.00	0.00
Benefits Expire		NA	NA		
Deductible Owed YTD	Standard	0.00	0.00	0.00	0.00
	Preventative	0.00	0.00	0.00	0.00
	Other	0.00	0.00	0.00	0.00

Alternate Cases:

Case notes:

Insurance benefits are ESTIMATED based upon information from the insurance company. It is not a guarantee of payment. Patient/Guardian is responsible for amount not paid by insurance. The fees listed above will be valid for up to 30 days.

Patient/Guardian agrees to pay their portion day of treatment. Payment will be made by:

_____Cash/Check ✓ Visa/MasterCard _____Care Credit

Patient/Guardian Signature

9-9-2020

Team Member Signature

www.chandlersmiles.com
800 S Dobson Rd, Ste. 8 Bldg B
Chandler, AZ 85224-5674 PHONE: (480)899-3425

REPORT DATE: 09/09/2020

AZORAL
FACIAL AND IMPLANT SURGERY

NISH S. SHAH, DMD, MD, FACS
Board Certified, Oral and Maxillofacial Surgeon

Date: 9/8/2020

Patient Name:

The following is an **estimate** of your recommended treatment.

Insurance Plan: Self Pay

Procedure Code	Tooth #	Description	AZ ORAL	Allowable Rate	Insurance Estimate	Patient Estimate
7250	8	Extraction, Residual Roots	265.00	265.00	-	265.00
6104	8	Bone Graft	660.00	660.00	-	330.00
4266	8	GTR Resorbable Membrane	643.00	643.00	-	200.00
6010	8	Surgical Implant Body, Endosteal	2,400.00	2,400.00	-	1,900.00
J7799	8	Exparel Injection	300.00	300.00	-	300.00
		Total	$ 4,268.00	$ 4,268.00	$ -	$ 2,995.00

Implant crown and abutment will be a separate fee with your dentist 3-4 months after implant is placed.
A 20 % deposit is collected at the time of scheduling.The remaining balance of is due

DEPOSIT 599.00 pd REMAINING BALANCE $ 2396.00

Patient (Parent or Legal Guardian) Signature

Date 9/9/20

Treatment Coordinator

Date 9/9/20

2450 W. Ray Rd., Ste. 1 • Chandler, AZ 85224
36327 N. Gantzel Rd., Ste 102 • San Tan Valley, AZ 85140
Phone 480.814.9500 Fax 480.814.9501

AZORAL
FACIAL AND IMPLANT SURGERY

NISH S. SHAH, D.M.D., M.D.
Board Certified, Oral and Maxillofacial Surgeon

IMPLANT PRE-OP INSTRUCTIONS WITH LOCAL ANESTHETIC

1. Please ***report to the office 10 minutes*** prior to your scheduled appointment. At this time, a follow-up visit will be scheduled, and any financial obligations will be settled.

2. If you are ill, need to reschedule your appointment, or have any questions, please call us at 480-814-9500. **Appointments cancelled less than 24 hours of scheduled time may be subject to broken appointment fee.*

3. For implant patients we ask that you start Peridex rinse 3-days prior to your surgery.

YOUR SURGERY APPOINTMENT WITH DR. SHAH IS ON:

September 17, 2020 AT Check-in 11:10

DEPOSIT DUE AT TIME OF SCHEDULING SURGERY $ 599.00 Paid

REMAINING AMOUNT DUE AT TIME OF SURGERY IS $ 2396.00

We accept Debit, all Major Credit Cards,
CareCredit & Chase Health Advance.
WE DO NOT ACCEPT PERSONAL CHECKS

Az Oral Facial implant Surgery
2450 W Ray Rd Suite 1
Chandler, AZ 852243595
480-814-9500

Service Date	09/09/2020
Patient ID	39327

Today's Charges $	0.00
Today's Credits $	599.00
Account Balance $	-599.00

Please Detach and keep for your records
Attending Doctor's Statement

Az Oral Facial implant Surgery
2450 W Ray Rd Suite 1
Chandler, AZ 852243595
480-814-9500

Date 09/09/2020
Patient ID 39327

Service Date	Description	Modifier	Tooth	POS	TOS	Units	Amount
09/09/2020	Visa CC PaymentVISA			0			$-599.00
09/09/2020	No charge Implant visit					1	$.00

Signature:

Nish S. Shah DMD MD

200703525 (Tax I.D.) 31035 (Med Lic.) D6015 (Den Lic.)

Total $ -599.00