LEOFF Application for Payment of Services

Case No: 21-5

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/Phone: _____ Email: _____

Describe Your Condition and Why It Is Duty Related: Restorative treatment. non related.

Describe the Service/Treatment Requested: decay removal.

Total Cost of Treatment/Service: $ 902.00

Amount Paid by Insurance/Medicare: $ 0.00

Amount Requested from the Board $ _____

Total request #1912.00

LEOFF member-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: _____

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: Paul Isaacson Provider's Telephone: (360) 357-8075

Clinic/Office Name: Olympia advanced Dentistry

Provider's Address: 1105 4th Ave E. Ste A Olympia, 98506

Describe the Patient's Current Condition and State Whether It Is Duty Related: non-duty related current decay

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: remove decay and fill with composite.

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs: no alternative tx

Provider's Signature: Paul E Isaacson DDS Date: 6/18/2021

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

STATEMENT OF SERVICES RENDERED

Olympia Advanced Dentistry
1105 4th Avenue East, Suite A
Olympia, WA 98506-4018

(360)357-8075

CHART NO.	PAGE NO.
100879	1

BILLING DATE
06/18/2021

GUARANTOR NAME AND MAILING ADDRESS

PATIENT	TOOTH	SURF	DESCRIPTION	CHARGE	CREDIT
			D9230:Analgesia-inhal of nitrou	80.00	
	6	MF	D2331:Resin-two surfaces, anter	270.00	
	7	DF	D2331:Resin-two surfaces, anter	270.00	
	8	F	D2330:Resin-one surface, anteri	202.00	
			Online Credit Card - Thank You		-902.00

PRIOR BALANCE		CURRENT CREDITS		CURRENT CHARGES		NEW BALANCE		DENTAL INS. EST.		PLEASE PAY
80.00	-	902.00	+	822.00	=	0.00	-	0.00	=	0.00

PATIENT	DATE	TIME	REASON
	Tuesday - July 6, 2021	12:30 pm	Resin1# 9, Resin1#10, Resin1#11
	Thursday - January 6, 2022	1:00 pm	PeriodicX, 4BWX, TopFlride, PerMaint

LEOFF Application for Payment of Services Case No: 21-5

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/Phone: _____ Email: _____

Describe Your Condition and Why It Is Duty Related: drill and Fill Not related

Describe the Service/Treatment Requested: drill & Fill

Total Cost of Treatment/Service: $ 707.00

Amount Paid by Insurance/Medicare: $ 0.00

Amount Requested from the Board $ _____

LEOFF member-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: _____

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: Paul Isaacson Provider's Telephone: 360.357.8075

Clinic/Office Name: Olympia Advanced Dentistry

Provider's Address: 1105 4th Ave East Ste A

Describe the Patient's Current Condition and State Whether It Is Duty Related: non-duty related current decay

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: remove decay and fill with composite

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs: no alternative treatment

Provider's Signature: Paul E Isaacson DMD Date: 6/18/2021

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

LEOFF Application for Payment of Services Case No: 21-5

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/Phone: _____ Email: _____

Describe Your Condition and Why It Is Duty Related: Cleaning Not related

Describe the Service/Treatment Requested: Cleaning

Total Cost of Treatment/Service: $ 303.00

Amount Paid by Insurance/Medicare: $ 0.00

Amount Requested from the Board $ _____

LEOFF member-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: _____

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: Kathy Iverson RDH, Provider's Telephone: (360) 357 8075

Clinic/Office Name: Olympia advanced Dentistry

Provider's Address: 1105 4th Ave East Ste. A Olympia, WA 98501

Describe the Patient's Current Condition and State Whether It Is Duty Related: Routine periodontal cleaning, non duty related.

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: 1e month routine check up, fillings to remove decay asap.

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

Provider's Signature: _____ Date: 6-15-2021

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

STATEMENT OF ACCOUNT

Olympia Advanced Dentistry
1105 4th Avenue East, Suite A
Olympia, WA 98506-4018

(360)357-8075

CHART NO.	PAGE NO.
100879	1
BILLING DATE	**DUE DATE**
06/15/2021	06/30/2021

CREDIT CARD #_____ EXP._____

NAME_____
(As it appears on card)

SIGNATURE _____

TYPE OF CARD_____

SECURITY CODE_____

AMOUNT ENCLOSED
$

GUARANTOR NAME AND MAILING ADDRESS

TO ENSURE PROPER CREDIT, PLEASE DETACH AND RETURN THIS PORTION OF THE STATEMENT WITH YOUR PAYMENT

PLEASE RETAIN THIS PORTION OF THE STATEMENT FOR YOUR RECORDS

DATE	DESCRIPTION	PATIENT'S NAME	CHARGES	CREDITS
05/15/2021	Balance Forward		0.00	
06/11/2021	D9230:Analgesia-inhal of nitrous oxid		80.00	
06/11/2021	D4910:Periodontal maintenance		223.00	
06/11/2021	Online Credit Card - Thank You			-303.00
06/14/2021	D2392:Resin composite-2s, posterior #18		330.00	
06/14/2021	D2392:Resin composite-2s, posterior #20		330.00	
06/14/2021	Senior Citizen Courtesy			-33.00
06/14/2021	Online Credit Card - Thank You			-627.00
06/14/2021	D9230:Analgesia-inhal of nitrous oxid		80.00	

CURRENT BALANCE	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	TOTAL BALANCE
80.00	0.00	0.00	0.00	80.00

Did you know we are accepting new patients? We would love to care for your friends and family!

PLEASE PAY THIS AMOUNT → 80.00

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