LEOFF Application for Payment of Services Case No: 21.6

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: _____ Active: _____ Retired: X

Member Telephone: _____ Police: _____ Fire: X

Member Address: _____

Alternate Contact/Phone: _____ Email: _____

Describe Your Condition and Why It Is Duty Related: _____

Describe the Service/Treatment Requested: See attached

Total Cost of Treatment/Service: $ _____ See attached

Amount Paid by Insurance/Medicare: $ _____

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: Mariela Morales Jimenez, MD Provider's Telephone: 509-248-3263

Clinic/Office Name: Cornerstone Medical Clinic

Provider's Address: 4003 Creekside Loop Yakima WA 98908

Describe the Patient's Current Condition and State Whether It Is Duty Related: Pt has seen his dentist who has determined dental work is needed to address cavities + dental decay. Not duty related.

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: The dentist determined the treatment is medically necessary as there is no alternative given infection risk due to poor dentition.

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs: See attached, 2 options presented, second one preferred

Provider's Signature: _____ Date: 6/8/2021

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

Steven B. Hemenway, D.D.S., PLLC
719 N 39th Ave, Ste 100
Yakima, WA 98902-6302
(509)453-3610 x

SECONDARY TREATMENT PLAN

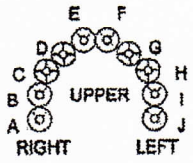
June 2, 2021

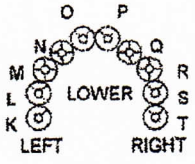
Page 1

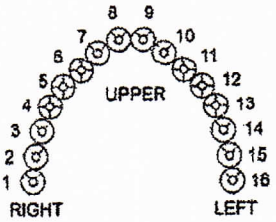
Prepared for:

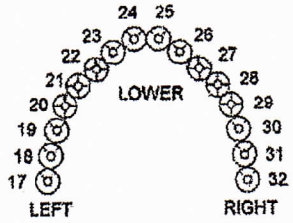
Group	Planned	Code	Dr	T	Surf.	Description	Patient	Insurance	Total	Accepted
1	06/02/21	2394.00	6	04	MODB	Resin Composite - 4+ Surface	550.00	0.00	550.00	No
1	06/02/21	2740.00	6	05		crown-porcelain/ceramic	1,400.00	0.00	1,400.00	No
1	06/02/21	2950.00	6	05		core buildup, incl pins	333.00	0.00	333.00	No
1	06/02/21	2332.00	6	07	MFD	Resin Composite - 3 Surface,	372.00	0.00	372.00	No
1	06/02/21	2332.00	6	10	MFD	Resin Composite - 3 Surface,	372.00	0.00	372.00	No
						TOTALS:	**3,027.00**	**0.00**	**3,027.00**	

Opt #1









ADDITIONAL COMMENTS

PLEASE NOTE: This is Dr. Hemenway's recommended treatment for you. All pricing above is strictly an estimate based on Dr. Hemenway's fees and is NOT a guarantee of payment from your insurance. Your insurance is a 3rd party payer and we do not have access to their fees, or contract limitations, therefore reimbursement may be less.

It is the policyholder's responsibility to know how much insurance they have available when scheduling treatment. If you are unaware of your insurance coverage, please check with your insurance company or human resource department to determine your exact benefits, contract limitations, waiting periods, and/or fee schedule.

Financial Arrangements
Deductible has not been included in above estimate.
This estimate expires in (30) days.

Call Ciara w/ questions 453-3610

I REQUEST AND AUTHORIZE THE DOCTOR AND/OR SUCH QUALIFIED ASSIGNEES TO PERFORM THE DENTAL WORK LISTED ABOVE.

Patient Signature: _____ Date: _____

Steven B. Hemenway, D.D.S., PLLC
719 N 39th Ave, Ste 100
Yakima, WA 98902-6302
(509)453-3610 x

PRIMARY TREATMENT PLAN

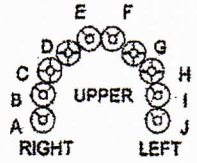
June 2, 2021

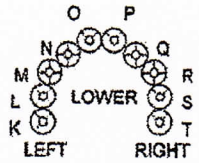
Page 1

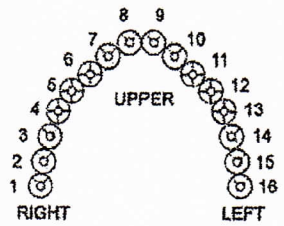
Prepared for:

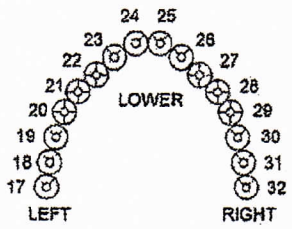
Group	Planned	Code	Dr	T	Surf.	Description	Patient	Insurance	Total	Accepted
1	06/02/21	2740.00	6	04		crown-porcelain/ceramic	1,400.00	0.00	1,400.00	No
1	06/02/21	2950.00	6	04		core buildup, incl pins	333.00	0.00	333.00	No
1	06/02/21	2740.00	6	05		crown-porcelain/ceramic	1,400.00	0.00	1,400.00	No
1	06/02/21	2950.00	6	05		core buildup, incl pins	333.00	0.00	333.00	No
1	06/02/21	2740.00	6	07		crown-porcelain/ceramic	1,400.00	0.00	1,400.00	No
1	06/02/21	2950.00	6	07		core buildup, incl pins	333.00	0.00	333.00	No
1	06/02/21	2740.00	6	10		crown-porcelain/ceramic	1,400.00	0.00	1,400.00	No
1	06/02/21	2950.00	6	10		core buildup, incl pins	333.00	0.00	333.00	No
						TOTALS:	**6,932.00**	**0.00**	**6,932.00**	

opt #2









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Deductible has not been included in above estimate.
This estimate expires in (30) days.

I REQUEST AND AUTHORIZE THE DOCTOR AND/OR SUCH QUALIFIED ASSIGNEES TO PERFORM THE DENTAL WORK LISTED ABOVE.

Patient Signature: _____ Date: _____