September 8, 2021

Cost summary for Case #21-8

Surgical implants and related work	$ 8,806.35
4 unit bridge on 3 implants	$ 8,648.00
Total request	$17,454.35

LEOFF Board Application for Payment of Services Case No: 21-8

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: _____ Alternate Contact Telephone: _____

Describe Your Condition and Why It Is Duty Related: _____

Describe the Service/Treatment Requested: 3 TITANIUM IMPLANTS

Total Cost of Treatment/Service: $ 8806.35

Amount Paid by Insurance/Medicare: $ _____

Amount Requested from the Board $ MAXIMUM POSSIBLE APPRECIATED

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: 8/12/21

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: Tahoe Oral Surgery + Implant Provider's Telephone: _____

Clinic/Office Name: _____

Provider's Address: _____

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

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

PT Missing posterior dentition and unable to properly chew food or tolerate partial denture.

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

Provider's Signature: _____ Date: 8/13/21

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

Revised 12/27/07

Location: \\Calvin\Personnel\Forms\

Tahoe Oral Surgery & Implant Center

Go Menu > History > Print

Account History

Account 111365
Budget 0.00
Mobile

Last Billing
Last Payment 5/14/2021
Pay Amount $2,235.35

Date	Name	Loc	Dr	Code	Description	Th/Srf/ Chk #	Bank#	D Claim	M Claim	Amount	Balance
2/24/21		SLT	RA	0140	LIMITED ORAL EVAL - PROBLEM					105.00	105.00
2/24/21		SLT	RA	0330	PANORAMIC FILM					0.00	105.00
2/24/21		SLT	RA	0004.2	PAYMENT - CREDIT CARD,					-862.00	-757.00
3/1/21		SLT	RA	0140	LIMITED ORAL EVAL - PROBLEM					0.00	-757.00
3/3/21		SLT	RA	7210	Surgical Extraction	29				328.00	-429.00
3/3/21		SLT	RA	6010	SURGICAL IMPLANT BODY:	29				2353.00	1924.00
3/3/21		SLT	RA	6104	BG at time of implant placement	29				511.00	2435.00
3/3/21		SLT	RA	0367	Cone Beam CT					357.00	2792.00
3/3/21		SLT	RA	6010	SURGICAL IMPLANT BODY:	~~29~~ 27				2353.00	5145.00
3/3/21		SLT	RA	7210	Surgical Extraction	27				328.00	5473.00
3/3/21		SLT	RA	6190.N	X-NAV Guide per clip	27				236.00	5709.00
3/3/21		SLT	RA	0004.2	PAYMENT - CREDIT CARD,					-5709.00	0.00
3/9/21		SLT	RA	99499.S	Doctible					0.00	0.00
3/17/21		SLT	RA	0171	Post-Op					0.00	0.00
5/14/21		SLT	RA	6010	SURGICAL IMPLANT BODY:	30				2353.00	2353.00
5/14/21		SLT	RA	0010	PAYMENT - CHECK, THANK YOU	209	9078			-2235.35	117.65
5/14/21		SLT	RA	0063	REDUCE BALANCE - WRITE-OFF					-117.65	0.00
8/4/21		SLT	RA	0171	Post-Op					0.00	0.00

per Lauren @ Tahoe Oral Surgeons DH 9/7/21

Balance	Current	Over 30	Over 60	Over 90	Over 120
0.00	0.00	0.00	0.00	0.00	0.00

Total #8806.35

Printed By: Lauren Bilderback
Printed On: 08/13/21 8:33 AM

LEOFF Board Application for Payment of Services Case No: 21-8

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: _____ Alternate Contact Telephone: _____

Describe Your Condition and Why It Is Duty Related: _____

Describe the Service/Treatment Requested: 4 UNIT BRIDGE ON 3 IMPLANTS

Total Cost of Treatment/Service: $ 86480

Amount Paid by Insurance/Medicare: $ _____

Amount Requested from the Board $ MAXIMUM POSSIBLE APPRECIATED

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: 8/12/21

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: Thomas Jarrett, DDS Provider's Telephone: 530-541-4405

Clinic/Office Name: Thomas Jarrett, DDS

Provider's Address: 965 Tahoe Keys Blvd., So Lake Tahoe, CA 96150

Describe the Patient's Current Condition and State Whether It Is Duty Related: Edentulous lower right mandible - teeth #27-30 to be replaced by implant supported prosthesis to restore proper function.

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: Replacing missing teeth necessary to restore masticatory function for proper digestion of food.

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:
No other reasonable treatment alternatives available as implants are already integrated into the mandibular bone.

Provider's Signature: [signature] Date: 8-12-21

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

Revised 12/27/07

Location: \\Calvin\Personnel\Forms\

THOMAS A. JARRETT, D .D. S.
965 TAHOE KEYS BLVD.
S LAKE TAHOE, CA 96150
(530)541-4405

STATEMENT OF SERVICES RENDERED

Thursday
August 12, 2021

ACCOUNT NAME AND ADDRESS

ACCOUNT NUMBER
421900

STATEMENT FOR PATIENT

PATIENT	CODE	DESCRIPTION	TH.	SURF.	AMOUNT	EST. INS
	6058	abutment supported crown	27		1,787.00	
	6057	Custom Fabric Abutment - Incl. Placement	27		732.00	
	6242	Pontic - Porcelain/Noble Metal	28		1,091.00	
	6058	abutment supported crown	29		1,787.00	
	6057	Custom Fabric Abutment - Incl. Placement	29		732.00	
	6058	abutment supported crown	30		1,787.00	
	6057	Custom Fabric Abutment - Incl. Placement	30		732.00	
	22	Senior Courtesy			432.00CR	
	3	Check Payment - Thank You Check No: 213			4,108.00CR	

PREVIOUS PATIENT BALANCE	TODAY'S CHARGES	TODAY'S PAYMENTS	NEW PATIENT BALANCE		PLEASE PAY THIS AMOUNT
0.00	8,648.00	4,540.00	4,108.00		4,108.00

Next Appt.	Day	Date	Time	Reason (** = Estimate)
	Wed	September 15, 2021	08:00a	Seat Abutment Supported Crown
	Mon	January 3, 2022	11:00a	Prophylaxis - Adult

Additional Comments