LEOFF Application for Payment of Services

Case No: 21-9

Please Print Clearly & Legibly - Incomplete Form Will Be Returned

A) This Section To Be Completed by Member											
Member Name:	_ A	ctive:	Retired:	4							
Member Telephone:		olice:		>							
Member Address:											
Alternate Contact/Phone:		mail:		'							
Describe Your Condition and Why It Is Duty Related:											
- pre-approval											
Describe the Service/Treatment Requested:	<u>drill</u>	and fr	11 40	YOWA							
Total Cost of Treatment/Service:	\$ <u> </u>	X \$2216.00									
Amount Paid by Insurance/Medicare:	\$ Ø. Ø	_									
Amount Requested from the Board	\$ 209 6 .00	\$2216.00									
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: 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	Prov	vider's Telephor	ne:340 BP	57-8075							
Clinic/Office Name: Ulum pro Adv											
Provider's Address: 10 7 4th Ave L	STE. A DIU	98506									
Describe the Patient's Current Condition and	d State Whether It Is	Duty Related:	decay.	<u> </u>							
Describe Your Recommended Treatment Pla	an and Why It Is Me	dically Necessa	rv: #4- h	1B All							
remove decay, #5-crown and buildup-removal of											
Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:											
no other treatment Eptien											
III OTTEN HELLINGEN	Ophici										
Provider's Signature:	sea Di	Date:	9/3/202	2)							

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

1105 4th Ave E, Suite A Olympia, WA 98506 PHONE:

www.coopermossdentistry.com

Olympia Advanced Dentistry

Name
Birthdate
Social Security Number
Chart Number

100879

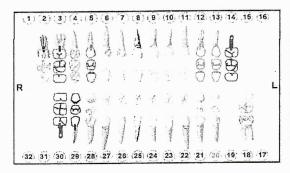
: TREATMENT CASE

Treatment Plan

DATE	VISIT	тоотн	SURF	CODE	PROV	DESCRIPTION	FEE	PATIENT
02/04/2021	3	4	MB	D2392	XX03	Resin composite-2s, posterior	330.00	330.00
02/04/2021	3	5		D0220	XX01	Intraoral Periapical Images	36.00	36.00
02/04/2021	3	5		D2740	XX01	Crown - porcelain/ceramic	1500.00	1500.00
02/04/2021	3	5		D2745	XX01	SEAT APC	0.00	0.00
02/04/2021	3	5		D2950	XX01	Core buildup, include any pins	350.00	350.00
" TOTALS "								

:: INSURANCE PROVIDER(S) ::
Primary Secondary

:: TOTALS :: Fee | Patient | | | | 2216.00 2216.00



:: FINANCIAL SUMMARY ::
Treatment Plan Total 2216.00

Alternate Cases:

Case notes

By signing below, I acknowledge that the amount set forth above as payable by my dental insurer is only an estimate, and that it is my responsibility to pay the total fees for the above-described treatment if my insurance company denies coverage. At the time of treatment, I agree to pay the amount indicated above as the patient's portion. If there is any remaining balance after my insurance has been processed, I agree to pay such remaining balance upon receipt of a billing statement.

Any balance not paid within 90 days of the date of actual treatment shall accrue interest at a rate of 1.5 percent per month and be considered a Delinquent Account. All payments made after 90 days shall be applied first to interest, and then to any outstanding treatment balance. Cooper Moss Advanced Dentistry reserves the right to submit a Delinquent Account for legal collection. The prevailing party in any proceeding to collect a Delinquent Account shall be entitled to reasonable attorneys' fees and costs related to such proceeding.

DATE: 09/03/202