LEOFF Board Application for Payment of Services Case No: _____

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: [redacted]

Member Telephone:

Member Address:

Alternate Contact: _____ Alternate Contact Telephone: _____

Describe Your Condition and Why It Is Duty Related: not related replace missing teeth

Describe the Service/Treatment Requested: replace missing teeth

Total Cost of Treatment/Service:	$ 2900.00	$2,700.00
Amount Paid by Insurance/Medicare:	$ 0	
Amount Requested from the Board	$ 2900.00	$2,700.00

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: [redacted] 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
(attach additional pages as needed)

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 Olympia, WA 98506

Describe the Patient's Current Condition and State Whether It Is Duty Related: Non duty related.

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: replacement for lower partial, to restore chewing function due to loss of teeth from perio health and decay

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs: No other options, implants will be more costly.

Provider's Signature: Paul E Isaacson DMD Date: 6/22/2026

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

Revised 12/27/07

Location: \\Calvin\Personnel\Forms\

Olympia Advanced Dentistry

Name [redacted]

.: TREATMENT CASE

Fills

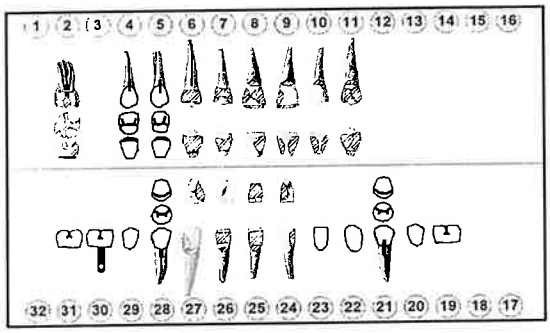
DATE	VISIT	TOOTH	SURF	CODE	PROV	DESCRIPTION	FEE	PATIENT
06/22/2026	1	19*31		D5214	XX03	Mand partl-cast metal w/resin	2600.00	2600.00
06/24/2026	1			00003	XX03	Lab Fees	100.00	100.00
						Visit 1 Totals:	2700.00	2700.00

:: INSURANCE PROVIDER(S) ::

Primary Secondary

:: TOTALS ::

Fee	Patient
2700.00	2700.00



:: FINANCIAL SUMMARY ::

Treatment Plan Total	2700.00
Estimated Deductible to be Applied	0.00
Estimated Insurance Payment	0.00
Estimated Patient's Portion	2700.00

:: 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:

Treatment Plan for lower plate # 19 – 31

Confirmed by dentist partial is to replace teeth #'s 19, 20,22,23,29,30 & 31 adn the cost is $2,700.00 - DH

www.olympiaadvanceddentistry.com

1105 4th Ave E, Suite A
Olympia, WA 98506 PHONE: (360)357-8075

REPORT DATE: 07/20/2026

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