LEOFF Board Application for Payment of Services Case No: 26-4

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: [redacted]

Member Telephon

Member Address:

Alternate Contact:

Describe Your Condition and Why It Is Duty Related: Abscess in molar, Requires Root canal + crown

Describe the Service/Treatment Requested:

Total Cost of Treatment/Service: $ 3,374.00

Amount Paid by Insurance/Medicare: $

Amount Requested from the Board $ 3,374.00

RECEIVED MAR 13 2026 CITY OF OLYMPIA CUSTOMER SERVICE

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: 3-4-26

Plea 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: _____ Provider's Telephone: _____

Clinic/Office Name: _____

Provider's Address: _____

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

See Attached form from McDonald Dentistry

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

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

Provider's Signature: _____ Date: _____

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\

McDonald Dentistry

Name [redacted]

1205 Harrison Ave NW
Olympia, WA 98502-5494
PHONE: (360)352-4008

.: TREATMENT CASE

Treatment Plan

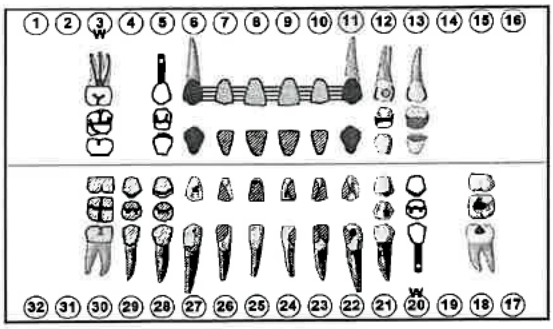
DATE	VISIT	TOOTH	SURF	CODE	PROV	DESCRIPTION	FEE	PATIENT
03/13/2026	1	3		D2950	XX02	Core buildup, include any pins	328.00	328.00
03/13/2026	1	3		D3330	XX02	Endo therapy - molar (ex rest)	1418.00	1418.00
03/13/2026	1	3		D3450	XX02	Root amputation-per root	0.00	0.00
03/13/2026	1	3		D9003	XX02	PREP/IMPRESSION	0.00	0.00
						Visit 1 Totals:	1746.00	1746.00
03/13/2026	2	3		D2740	XX02	Crown - porcelain/ceramic	1628.00	1628.00
						Visit 2 Totals:	1628.00	1628.00

:: INSURANCE PROVIDER(S) ::

Primary	Secondary

:: TOTALS ::

Fee	Patient
3374.00	3374.00



:: FINANCIAL SUMMARY ::

Treatment Plan Total	3374.00
Estimated Deductible to be Applied	0.00
Estimated Insurance Payment	0.00
Estimated Patient's Portion	3374.00
Family Balance	0.00
Fee Expiration Date	11/19/2013

:: 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:

REPORT DATE: 03/13/2026