08/07/2026 01:47 PM (GMT-7)

LEOFF Application for Payment of Services Case No: 26-8 #2

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: [redacted] Active: _____ Retired: X

Member Telephone: [redacted] Police: _____ Fire: X

Member Address: [redacted]

Alternate Contact/Phone: _____ Email [redacted]

Describe Your Condition and Why It Is Duty Related: dental

Describe the Service/Treatment Requested: repair, crown #21

Total Cost of Treatment/Service: $ 2126.50

Amount Paid by Insurance/Medicare: $ _____

Amount Requested from the Board $ 2126.50

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: [redacted] Date: 9-5-25

Please attach a copy of the Power of Attorney signed by the alternate contact.

B) This Section To Be Completed by Member's Attending Health Care Provider

Provider's Name: Paul Isaacson DDS Provider's Telephone: (360) 357-8075

Clinic/Office Name: Olympia Advanced Dentistry

Provider's Address: 1105 4th Ave E. ste:A Olympia, WA 98506

Describe the Patient's Current Condition and State Whether It Is Duty Related:
Extensive breakdown around old/d restoration needing full coverage protection to maintain tooth #21

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary:
#21 Full crown restoration to help maintain tooth functionality

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:
None, tx required to maintain tooth #21

Provider's Signature: Paul E Isaacson DDS Date: 9-5-2025

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

STATEMENT OF SERVICES RENDERED

Olympia Advanced Dentistry
1105 4th Avenue East, Suite A
Olympia, WA 98506-4018

(360)357-8075

CHART NO.	PAGE NO.
100879	1

BILLING DATE
09/05/2025

GUARANTOR NAME AND MAILING ADDRESS

[redacted]

PATIENT	TOOTH	SURF	DESCRIPTION	CHARGE	CREDIT
[redacted]			D9230:Analgesia-inhal of nitrou	85.00	
	21		D2740:Crown - porcelain/ceramic	1651.00	
	21		D2745:SEAT APC	0.00	
	21		D2950:Core buildup, include any	401.00	
			VISA/MC Payment -Thank You		-2126.50

PRIOR BALANCE		CURRENT CREDITS		CURRENT CHARGES		NEW BALANCE		DENTAL INS. EST.		PLEASE PAY
-10.50	-	2126.50	+	2137.00	=	0.00	-	0.00	=	0.00

PATIENT	DATE	TIME	REASON
[redacted]	Thursday - September 18, 2025	9:30 am	PerMaint, PC
	Monday - January 19, 2026	9:30 am	PerMaint, PC