08/07/2026 01:50 PM (GMT-7)

LEOFF Board Application for Payment of Services

Case No: 26-8 #3

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: [redacted]

Member Telephone: [redacted]

Member Address: [redacted]

Alternate Contact: _____ Alternate Contact Telephone: _____

Describe Your Condition and Why It Is Duty Related: Root canal & eval treatment required on #6 [redacted]

Describe the Service/Treatment Requested: Root canal & eval

3/4/26

Total Cost of Treatment/Service: $ 1932.00 + 764.27 = 2696.27

Amount Paid by Insurance/Medicare: $ 0

Amount Requested from the Board $ 1932.00 3/10/26

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: 3-10-26

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: RAJNISH ROHILA Provider's Telephone: 360-491-6995

Clinic/Office Name: Olympia Endodontic Group

Provider's Address: 208 Lilly Rd NE Suite D Olympia, WA 98506

Describe the Patient's Current Condition and State Whether It Is Duty Related: Tooth #6 pulp is necrotic with swelling.

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: endodontic therapy needed to treat root canal infection.

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

Provider's Signature: [signature] Date: 3-10-26

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\

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
03/09/2026

GUARANTOR NAME AND MAILING ADDRESS

[redacted]

PATIENT	TOOTH	SURF	DESCRIPTION	CHARGE	CREDIT
[redacted]			Intraoral Periapical Images	40.00	
			Intraoral-periapical each add'l	35.00	
			Analgesia-inhal of nitrous oxid	100.00	
	6	L	Resin-one surface, anterior	254.00	
	6	MDLF	Resin-4+ w/incis angle-anterior	463.00	
	7	MDLF	Resin-4+ w/incis angle-anterior	463.00	
			Senior Citizen Courtesy		-67.75
			VISA/MC Payment -Thank You		-1287.25

$175.00 split between #6 + #7 = $87.50 each

3/9/26 #6 $80.50 less 50% - 40.23 $764.27

3/9/26 #7 $50.50 less 50% - 25.25 $522.98

#6 new board approval - additional work on 3/9/26

PRIOR BALANCE		CURRENT CREDITS		CURRENT CHARGES		NEW BALANCE		DENTAL INS. EST.		PLEASE PAY
0.00	-	1355.00	+	1355.00	=	0.00	-	0.00	=	0.00

PATIENT	DATE	TIME	REASON
[redacted]	Thursday - April 23, 2026	10:30 am	AnlgNitOx, PerMaint

STATEMENT OF SERVICES

Date	Name	Dr	Code	Description	Th / Surface Check #	Amount	Balance
3/10/2026	[redacted]	RR	0140	EXAM - LIMITED PROBLEM FOCUSED	6	128.00	128.00
3/10/2026		RR	0220	X-RAYS, FIRST PERIAPICAL	6	49.00	177.00
3/10/2026		RR	0364	CBCT SCAN	6	375.00	552.00
3/10/2026		RR	3310	ROOT CANAL-ANTERIOR	6	1202.00	1754.00
3/10/2026		RR	2330	COMPOSITE RESIN, 1 SURFACE-	6 L	223.00	1977.00
3/10/2026		RR	9230	NITROUS	6	135.00	2112.00
3/10/2026		RR	0004	PAYMENT-CREDIT CARD, THANK YOU		-1932.00	180.00
3/10/2026		RR	0060	REDUCE BALANCE - PROF COURTESY		-180.00	0.00
	Tooth #6		3/10/26 3/9/26	$1,932.00 $ 764.27 $2,696.27			

Balance	Current	Over 30	Over 60	Over 90	Over 120	2026 Payments
0.00	0.00	0.00	0.00	0.00	0.00	1932.00

Account Information

[redacted]

Account # 703995
Home 360-528-7392

Last Billing
Last Private Payment 3/10/2026
Budget 0.00

Thank you!

Provider

Rajnish Rohila DDS
208 Lilly Rd Ne Suite D
Olympia, WA 98506

360-491-6945

Billing Date

7/20/2026

Patient	Next Appointment Date	Time	Reason