Fire Pension Board Meeting Agenda

July 17, 2024 9:30 a.m. via Microsoft Teams

1.) Approval of minutes for May 15, 2024

2.) Bills and Pension Rolls:

PENSION ROLL		
Budgeted Amount	$720,000.00	
April 2024	$56,886.76	
Remaining budget	**$448,852.55**	**62.34%**
MEDICAL CLAIMS		
Budgeted amount	$1,792,000.00	
April 2024	$119,626.90	
April 2024 HMA fees	$14,927.08	
Remaining budget	**$1,221,897.36**	**68.19%**

PENSION ROLL		
Budgeted Amount	$720,000.00	
May 2024	$56,886.76	
Remaining budget	**$391,965.79**	**54.44%**
MEDICAL CLAIMS		
Budgeted amount	$1,792,000.00	
May 2024	$111,193.99	
May 2024 HMA fees	$11,572.68	
Remaining budget	**$1,099,130.69**	**61.34%**

3.) Special Bills for Board Review:

Member #82	Dental crowns need to be installed in the amount of $2834.

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name
(please print) [redacted]

1. Diagnosis: Dental crowns
2. Prognosis: need to be installed
3. Type of Treatment(s) or Procedure: Dental
4. Cost of treatments/service: $ 2834.00
5. Request to the board for this specific treatment or procedure:

dental

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

EVERETT
WASHINGTON

City of Everett
Fire & Police Pension
2930 Wetmore EVERETT,
WA 98201
(425) 257-7024

CLAIM FORM

PENSION BOARD APPROVAL:
I certify that the named patient is authorized to receive the described medical care at the expense of the City of Everett Uniformed Personnel Pension Fund. Payment is approved by board action this date. I am authorized to authenticate and certify said claim.

City Clerk or Secretary of Board _____ Date _____

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE'S NAME	☐ ACTIVE ☒ RETIRED	DATE OF BIRTH	TELEPHONE NO.	☐ POLICE ☒ FIRE
[redacted]		[redacted]		☒ MALE ☐ FEMALE

THIS SPACE FOR OFFICE USE ONLY

ACCOUNT NUMBER	VOUCHER NO.	VENDOR NO.	DESCRIPTION	AMOUNT
☐ 6375380000250 ☐ 6385380000250			☐ MED SERV ☐ RX ☐ CHIRO SERV ☐ REIMB ☐ OTHER	

I certify that the information and charges here shown are true and correct, and that these services and/or medications were received by me and that I am liable for these charges. I hereby authorize all doctors, pharmacists, hospitals or other instiutions rendering care and treatment to furnish the Fire/Police Pension Board with full information regarding treatment rendered (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish the Fire/Police Pension Board with information regarding benefits to which I may be entitled. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby assign benefit to the supplier/vendor below.

DATE July 2, 2024 E[redacted]

STATEMENT OF ATTENDING PHYSICIAN OR OTHER SUPPLIER/VENDOR CHARGES

DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIAGNOSIS CODE OTHER THAN ICDA USED, GIVE NAME)

REPORT OF SERVICES (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE IF USED (IF CODE OTHER THAN CPT ** USED, GIVE NAME	CHARGES
Not scheduled	Everett	Dental crown For pre approval For dental work		2834.00

DO NOT WRITE IN THIS SPACE

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

TOTAL CHARGES $ _____

TOTAL PAYMENTS $ _____

DATE	SUPPLIER/VENDOR NAME (PRINT)	SIGNATURE	TELEPHONE
STREET ADDRESS	CITY OR TOWN	STATE OR PROVIDENCE	ZIP CODE

514-409 (REV. 6/06)

PENSION BOARD

All Smiles Northwest

Name [redacted]

.: TREATMENT CASE

Treatment Plan

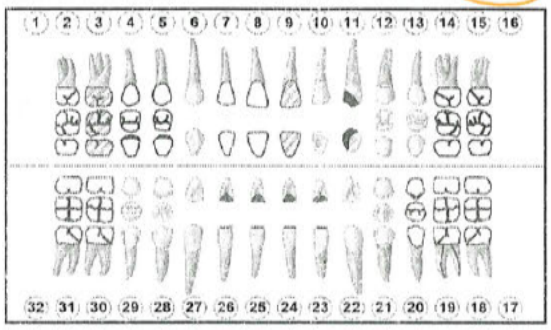
DATE	VISIT	TOOTH	DESCRIPTION	FEE	PATIENT	PRIMARY
04/25/2023	1	7	Crown - porcelain/ceramic	1200.00	1200.00	0.00
04/25/2023	1	7	Core buildup, include any pins	217.00	217.00	0.00
04/25/2023	1	8	Crown - porcelain/ceramic	1200.00	1200.00	0.00
04/25/2023	1	8	Core buildup, include any pins	217.00	217.00	0.00
02/13/2024	1		3D Scan - CROWN/ RESTORATION	0.00	0.00	0.00
			Visit 1 Totals:	2834.00	2834.00	0.00

:: INSURANCE PROVIDER(S) ::

Primary	Secondary
Health Care Management Admin	

:: TOTALS ::

Fee	Patient	Primary		
2834.00	2834.00	0.00		



Alternate Cases:

Case notes:

Insurance benefits are ESTIMATED based upon information from the insurance company. It is not a guarantee of payment. Patient/Guardian is responsible for amount not paid by insurance. The fees listed above will be valid for up to 30 days.

Patient/Guardian agrees to pay their portion day of treatment. Payment will be made by:

_____Cash/Check _____Visa/MasterCard _____Finance Pgm

_____

Patient/Guardian Signature

_____

Team Member Signature

www.allsmilesnw.com
3802 Colby Ave Ste 3
Everett, WA 98201-4940 PHONE: (425)252-9333

REPORT DATE: 05/07/2024