6/2/2026

DISABILITY BOARD AGENDA
210 W. 6TH AVE, KENNEWICK CITY HALL
CASCADE CONFERENCE ROOM

11:30 AM

1. **CALL TO ORDER**
2. **ATTENDANCE**
3. **PUBLIC COMMENT**
4. **APPROVAL OF MINUTES**
   a. Approval of the minutes dated May 5, 2026
5. **TREASURER'S REPORT**
   a. Treasurer's Report: April 2026
6. **RECCURING CLAIMS**
   Summary of claims for signature.
   a. Police Member #15
7. **NEW BUSINESS**
   a. Fire Member #19 Knee Aspiration Reimbursement Request
   b. Police Member #25 Massage Reimbursement Request
   c. Fire Member #28 Imaging & RX Reimbursement Request
   d. Fire Member #28 RX Reimbursement Request
   e. Police Member #5 RX Reimbursement Request
   f. Police Member #5 Eyeglasses & RX Reimbursement Request
   g. Fire Member #21 Ambulance Transport Reimbursement Request
8. **UNFINISHED BUSINESS**
   a. Fire Member #21 Hospice Claim Status/Revisit
9. **BOARD COMMENTS/DISCUSSION**
10. **ADJOURNMENT**

NEXT MEETING DATE: JUNE 2, 2026

DISABILITY BOARD
REGULAR MEETING
May 5, 2026 - DRAFT

1. **CALL TO ORDER:** Police Representative Jim Kraft called the regular meeting of the Kennewick Disability Board to order at 11:30 a.m.

2. **ATTENDANCE:** The at-large position is vacant.

Board Members Present:	City Staff Present:
Chuck Torelli, *Mayor Pro Tem*	**Jessica Platt,** *Finance Director*
Jim Kraft, *Police Representative*	**Liz D'Hondt,** *Accounting Specialist, Board Secretary*
Dennis Waters, *Fire Representative*	**Kristi Smith**, *Disability Board Benefits Administrator*
Brad Klippert, *Councilmember*	

3. **PUBLIC COMMENT:** NONE

4. **APPROVAL OF MINUTES:** The minutes of March 3, 2026, and April 7, 2026, were unanimously approved as presented.

5. **NEW BUSINESS:**
   a. **Police Member #25 Dental Crown Reimbursement Request:** The claim submitted differed from the receipted total by two cents. The Board approved reimbursement for the receipted amount of $680.86 instead of the submitted amount of $680.84.
   b. **Treasurer's Report: March 2026:** Ms. Platt delivered the Treasurer's reports and analytics for March 2026. OPEB funding for January through March was slightly down due to lower water consumption but is expected to increase with warmer weather.
6. **UNFINISHED BUSINESS:**
   a. **Fire Member #10 SSA Medicare Retro Reimbursement Request Follow Up:** The Board discussed the Medicare reimbursement request submitted for prior years. Legal counsel confirmed the Board is not required to reimburse beyond the six-month window outlined in Board policy. The Board approved reimbursement for the six-month period prior to the March 2026 submission date, with no reimbursement approved for periods prior to September 2025, due to required documentation not being submitted annually by the member.
   b. **Fire Member #21 Hospice Claim Status:** Staff is continuing research.

7. **BOARD COMMENTS/DISCUSSION:**
   a. Staff reported that five members have not yet submitted the required Medicare Reimbursement forms, and reminder letters were sent.
   b. Staff is researching Regence coverage related to specific cataract procedures.

8. **ADJOURNMENT:** Chair Kraft concluded the meeting concluded at 11:38 p.m.

Draft
Elizabeth D'Hondt
Disability Board Secretary

CITY OF KENNEWICK

OTHER POST EMPLOYMENT BENEFITS

TRUST FUND

Preliminary Financial Statements

April 30, 2026

CITY OF KENNEWICK

Other Post Employment Benefits Trust Fund

Balance Sheet
April 30, 2026

	Current Year	Prior Year
Assets		
Equity in Pooled Cash & Investments	$ 6,032,917	$ 5,720,088
Investments	-	$ -
Interest Receivable		
Total Assets	$ 6,032,917	$ 5,720,088
Liabilities		
Accounts Payable	$ 14,572	$ 14,330
Total Liabilities	14,572	14,330
Fund Balance		
Committed Fund Balance	6,018,345	5,705,758
Total Fund Balance	6,018,345	5,705,758
Total Liabilities and Fund Balance	$ 6,032,917	$ 5,720,088

CITY OF KENNEWICK

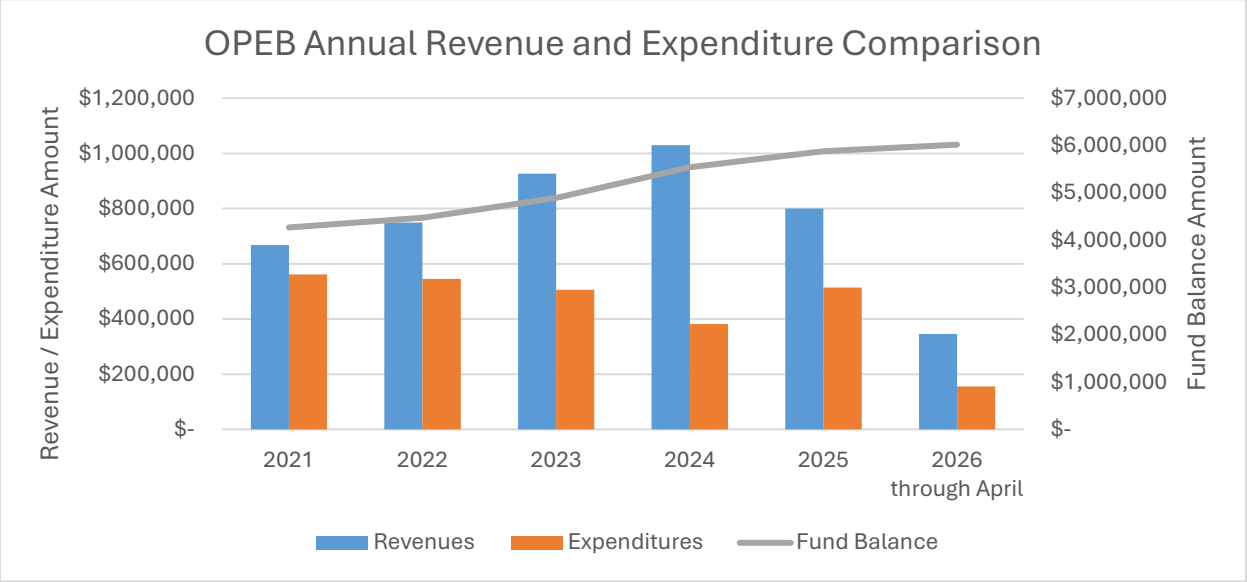
Other Post Employment Benefits Trust Fund

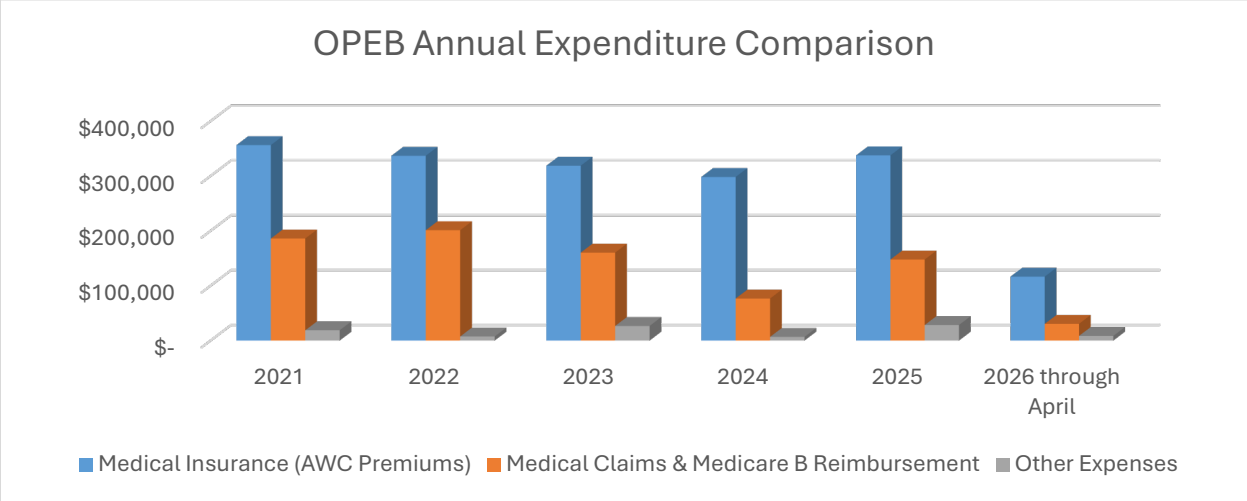
Income Statement
April 30, 2026

	2026 Budget	Year To Date	Over (Under) Budget	Prior Year To Date
Revenues:				
Water and Sewer Utility Tax	$ 590,000	$ 239,385	$ (350,615)	$ 243,060
Investment Interest	163,500	65,233	(98,267)	67,868
Expense Reimbursements	-	40,687	40,687	-
Total Revenues	753,500	345,305	(408,195)	310,928
Expenditures:				
Medical Insurance	348,500	116,523	(231,977)	114,638
Medical and Prescriptions	205,000	30,445	(174,555)	31,581
Disability Board Secretary	2,000	-	(2,000)	-
Office Supplies	50	-	(50)	-
Postage Expense	300	-	(300)	29
Travel and Training	2,000	857	(1,143)	-
Contractual/Consulting Services	12,500	7,597	(4,903)	-
Copier Charges	18	-	(18)	59
Total Expenditures	570,368	155,422	(414,945)	146,307
Net Income (Loss)	183,133	189,883	6,751	164,622
Beginning Fund Balance	5,828,461	5,828,461	-	5,541,137
Ending Fund Balance	$ 6,011,594	$ 6,018,345	$ 6,751	$ 5,705,758

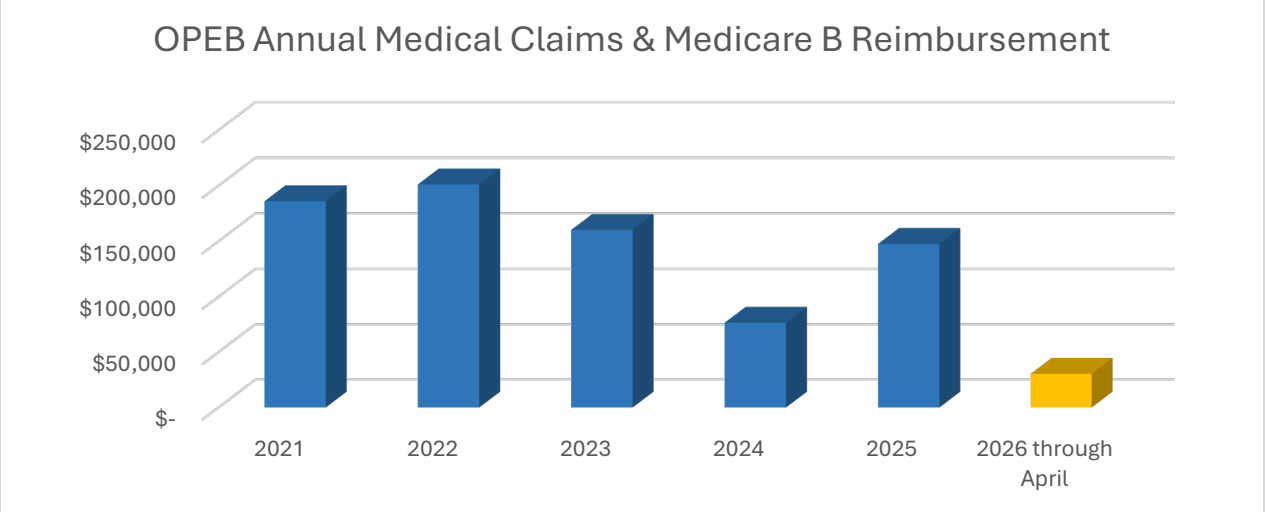
City of Kennewick
Other Post Employment Benefits Trust (OPEB) Fund
April 30, 2026

Revenues and Expenditures

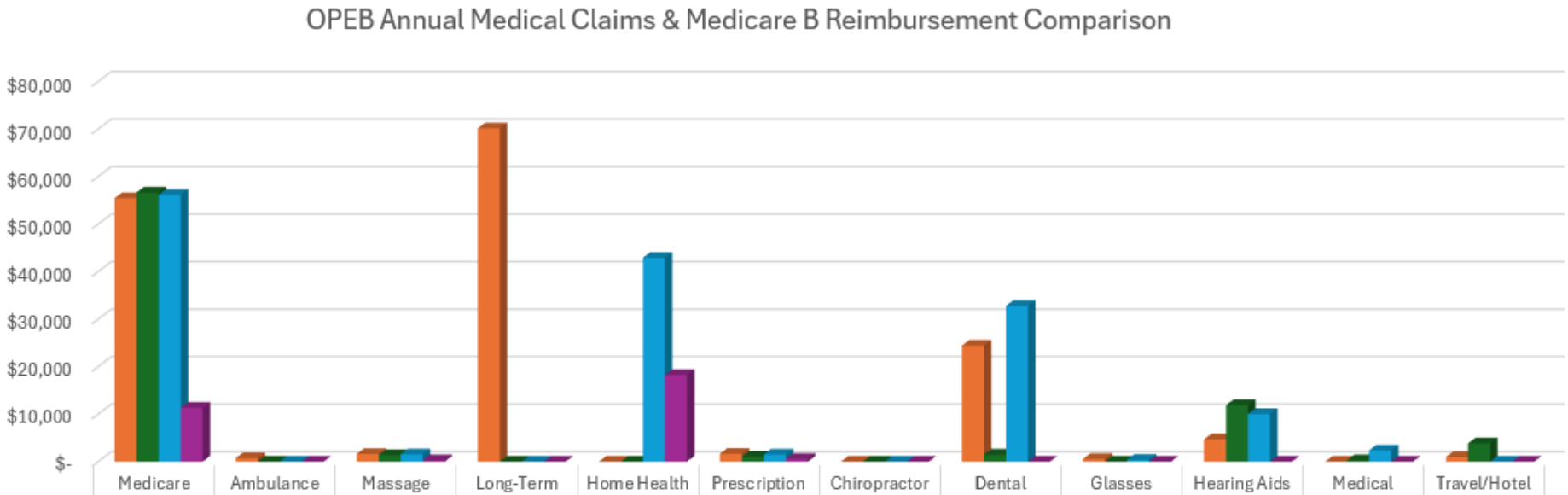




Medical Claims & Medicare B Reimbursement



City of Kennewick
Other Post Employment Benefits Trust (OPEB) Fund
April 30, 2026



	Medicare Part B	Ambulance	Massage	Long-Term Care	Home Health	Prescription Medication / Other	Chiropractor	Dental	Glasses (Frames/Lenses)	Hearing Aids	Medical Supplies	Travel/Hotel Reimbursement
2023	$55,447	$735	$1,625	$70,136	$-	$1,641	$-	$24,430	$564	$4,699	$-	$997
2024	$56,655	$-	$1,382	$-	$-	$1,040	$-	$1,477	$-	$11,880	$275	$3,864
2025	$56,141	$-	$1,550	$-	$42,884	$1,513	$-	$32,790	$382	$10,045	$2,368	$-
2026 through April	$11,353	$-	$300	$-	$18,226	$566	$-	$-	$-	$-	$-	$-

MEETING DATE: 06/02/2026

DISABILITY BOARD - POLICE

BUDGET NO. J2517210 . 520012

Member #	Date of Claim	Claim Type - Category	Code	Provider	TOTAL
15	3/7/2026	Prescription	1040	Elk Drug	$ 10.84
15	3/20/2026	Prescription	1040	Elk Drug	$ 10.84
15	4/3/2026	Prescription	1040	Elk Drug	$ 10.84

$ 32.52

JIM KRAFT, POLICE REPRESENTATIVE

DENNIS WATERS, FIRE REPRESENTATIVE

BRAD KLIPERT, COUNCILMEMBER

CHUCK TORELLI, MAYOR PRO TEM

LEOFF I – CERTIFICATION CLAIM FORM – Police

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [ ] _____

Date of Service	Condition or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
Mar 7 - 2026	Pill Pak	Elks Drug	10.84	10.84
Mar 20 - 2026	Pill Pak	Elks Drug	10.84	10.84
Apr 3 - 2026	Pill Pak	Elks Drug	10.84	10.84

TOTAL: 32.52

[redacted] Apr 9 - 2026

Print Name / Signature / Date

Board Use Only

RECEIVED 4/16/26

POLICE MEMBER #15

Sale

Elk Drug
176 E. Main Street
Dayton, WA 99328
Ph : 509-382-2536

Receipt: [redacted]
Date: 04/03/26 10:01AM
Cashier: Angela
Register: POS Lane2

Item	Flags	Qty	Price	Value
Bubble PK 2 WK	T	1x	$10.00	$10.00

Flags: T=Taxable F=FSA R=Rx P=Promo A=Auto Refill

Item count:1

Subtotal	$10.00
Standard Tax	$0.84
Total	**$10.84**
Tender Credit [redacted]	$10.84

Mastercard Card - Approved
Amount:$10.84
M[illegible]ard:[redacted]
[illegible]tion:CREDIT
Approval:G16[illegible]
Response Code:0
Entry Method:Contactlessicc
[illegible]:[redacted]
[illegible]:[redacted]
Cryptogram:[redacted]

[illegible]tomer Copy

Sale

Elk Drug
176 E. Main Street
Dayton, WA 99328
Ph : 509-382-2536

Receipt: [redacted]
Date: 03/20/26 11:47AM
Cashier: Danielle
Register: POS Lane2
Customer: [redacted]

Item	Flags	Qty	Price	Value
Rx [redacted]	RF			$0.00
Rx	RF			$0.00
Rx	RF			$0.00
Rx	RF			$0.00
Rx	RF			$0.00
Rx	RF			$0.00
Rx	RF			$0.00
Bubble PK 2 WK	T	1x	$10.00	$10.00

Flags: T=Taxable F=FSA R=Rx P=Promo A=Auto Refill

Rx count:7
Retail count:1
Total count:8

Rx Total:$0.00
Retail Total:$10.00

Subtotal	$10.00
Standard Tax on $10.00	$0.84
Total	**$10.84**
Tender Credit [redacted]	$10.84

Mastercard Card - Approved
Amount:$10.84
Mastercard:[redacted]
Transaction:CREDIT
Approval:[redacted]

Sale

Elk Drug
176 E. Main Street
Dayton, WA 99328
Ph : 509-382-2536

Receipt: [redacted]
Date: 03/07/26 10:09AM
Cashier: Danielle
Register: POS Lane2

Item	Flags	Qty	Price	Value
Bubble PK 2 WK	T	1x	$10.00	$10.00

Flags: T=Taxable F=FSA R=Rx P=Promo A=Auto Refill

Item count:1

Subtotal	$10.00
Standard Tax	$0.84
Total	**$10.84**
Tender Credit [redacted]	$10.84

Mastercard Card - Approved
Amount:$10.84
Mastercard:[redacted]8282
Transaction:CREDIT
Approval:[redacted]
Response Code:0
Entry Method:Contactlessicc
MASTERCARD[redacted]
Trace Code:[redacted]
Cryptogram:[redacted]

Customer Copy

LEOFF I – CERTIFICATION CLAIM FORM – FIRE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Fire Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [X] City Fire pension

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
6-9-2025	Knee problmes	Joshua Morgan	$ 786.00	$ 0-

TOTAL: 0

[redacted] 4-13-2026
Print Name **Signature** **Date**

Board Use Only

RECEIVED 4/16/26

FIRE MEMBER #19

KADLEC

Kadlec RMC SBO PP
PO BOX 31001-3496
Pasadena, CA 91110-3496

[redacted]

Patient: [redacted]
This is who received the services for this bill.
Guarantor ID #: [redacted]
Bill ID: [redacted]
Use to find your bill if you pay online or by phone.
Invoice printed: **Apr 4, 2026**

Our financial assistance program provides free and low-cost care to those who are eligible. Learn more at **www.providence.org/financialhelp**.

Nuestro programa de assistencia financiera brinda atención gratuita y de bajo costo a quienes son elegibles. Obtenga más información en **www.providence.org/financialhelp**.

Pay over time with no interest
Start a payment plan by visiting **pay.kadlec.org** or call us to discuss flexible payment options at **(855) 367-1343**

Account summary

Your total is $1,978.00

You have one bill totaling **$1,978.00** due **May 9, 2026**. You can pay your balance online, make a partial payment, or set up a 0% interest payment plan.

See back for details

Total billed	$1,978.00
Insurance paid REGENCE MEDICARE	-$0.00
Total due	**$1,978.00**

FOLD OR CUT AND DETACH AREA BELOW TO SEND WITH PAYMENT

Physician services

Due date: May 9, 2026

Larry's visit on June 9, 2025

Insurance applied

Location: Kc Nw Osm Spaulding | Clinician: Joshua Israel Morgan

Visit Account #: [redacted]

Bill details

Service	Total billed
Hc Pr Rx Hyaluronan Or Derivative (Gel-One) Inj 1 Ea	$1,192.00
Drain/Inj Joint/Bursa W/O Us	$786.00

Subtotal billed	$1,978.00
Insurance adjusted	–$0.00
Insurance paid	–$0.00
Amount you owe (subtotal)	**$1,978.00**

Your bill summary

KADLEC

Total billed	$1,978.00
Insurance adjusted	-$0.00
Insurance paid	-$0.00
Total post-insurance	$1,978.00
Total due	**$1,978.00**

Continued on next page

DETACH AREA BELOW TO SEND WITH PAYMENT

Notice of Denial of Payment

Date: March 30, 2026

Member number: [redacted]

Claim number:

Name: [redacted]

Provider: Morgan, Joshua I.
1351 FOWLER ST
STE 110
RICHLAND, WA 99352

Coverage for your medical services/items was denied

We've denied the payment of medical services/items or Medicare Part B drug listed below that you or your provider requested:

Claim Line	Date of Service	Type of Service	Charge	Denial Code
1	06/09/2025	Aspiration and/or injection of fluid from large joint (2061050)	$786.00	LAP

Why was coverage denied?

We denied the payment of medical services/items or Medicare Part B drug listed above because:

Denial Code	Denial Explanation
LAP	This line item is not payable as it is associated with a service that is not medically necessary.

Share a copy of this decision with your provider and discuss next steps. If your provider asked for coverage on your behalf, we already sent them a copy of this denial notice.

You have the right to appeal our decision

You have the right to ask Regence MedAdvantage to review our decision by asking us for an appeal within **65 calendar days** of the date of this notice. If you ask for an appeal after 65 days, you must explain why your appeal is late. See "How to ask for an appeal with Regence MedAdvantage" on the next page.

How to keep your services while we review your case: If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed. **For service to continue, you must ask for an appeal within 10 days** of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should keep getting the service. You may have to pay for these services if you lose your appeal.

If you want someone else to act for you

You can name a relative, friend, attorney, provider, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-888-319-8904 to learn how to name your representative. TTY users call 711.

Good morning Kristi,

I researched the information we have on this claim, and it appears this service needed a preauthorization that was denied. That is the reason the claim denied as it was determined not medically necessary when the preauthorization was requested. There is an option for the provider to appeal the decision or the member to appeal the decision as well. That information was sent to the member around 4/4/26 in a letter from Regence.

Thank you,

Flor Patterson

Medicare Customer Service Ambassador

(800) 541-8981 Ext: 6572

M-F 7 A.M-4 P.M

LEOFF I – CERTIFICATION CLAIM FORM – Police

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits;** and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [ ] LEOFF 1

Date of Service	Condition or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
4/13/2026	SORE BACK	MASSAGE TRI-CITIES	$100	$100
4/22/2026	SORE BACK	MASSAGE TRI-CITIES	$100	$100

TOTAL: $200

[redacted] [redacted] 5/4/2026

Print Name Signature Date

Board Use Only

RECEIVED VIA EMAIL 5/4/26

POLICE MEMBER #25

Massage Tri-Cities
4206 West 24th Avenue Suite A101
Kennewick, WA 99338 United States
nancy_hisaw@live.com | (509) 845-6722

Invoice [redacted]

Issue date
Apr 13, 2026

Invoice #000041

WA state License # MA00024917. NPI - 1144467895. CPT Code - 97140.

Customer
[redacted]

Invoice Details
PDF created April 13, 2026
$100.00

Payment
Due April 13, 2026
$100.00

Items	Quantity	Price	Amount
60 Min Massage with Nancy Doss LMT Whether you are looking for light to medium pressure general relaxation, or firm pressure deep tissue and/or trigger point work this is a 60 min massage your way. As your therapist I will communicate with you in order to customize your experience.	1	$100.00	$100.00

Subtotal $100.00

Total Paid $100.00

Payments
Apr 13, 2026 [redacted] $100.00

View online

To view your invoice go to https://squareup.com/u/HNJcQ6Ai
Or open the camera on your mobile device and place the QR code in the camera's view.

Massage Tri-Cities
4206 West 24th Avenue Suite A101
Kennewick, WA 99338 United States
nancy_hisaw@live.com | (509) 845-6722

Invoice [redacted]

Issue date
Apr 22, 2026

Invoice #000042

WA state License # MA00024917. NPI - 1144467895. CPT Code - 97140.

Customer
[redacted]

Invoice Details
PDF created April 22, 2026
$100.00

Payment
Due April 22, 2026
$100.00

Items	Quantity	Price	Amount
60 Min Massage with Nancy Doss LMT Whether you are looking for light to medium pressure general relaxation, or firm pressure deep tissue and/or trigger point work this is a 60 min massage your way. As your therapist I will communicate with you in order to customize your experience.	1	$100.00	$100.00

Subtotal $100.00

Total Paid $100.00

Payments
Apr 22, 2026 [redacted] $100.00

[redacted]

Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

2057 Commerce Dr
PO Box 1827
Medford OR 97501
www.regence.com

Forwarding Service Requested

**********ALL FOR AADC 990
PB-IND-17-ENV 14986 47
[redacted]

Plan Subscriber: [redacted]
Subscriber ID:
Group Name:
Group ID:

Check Amount: $200.00
Check Number: 0108407539
Check Date: 04/20/2026

What is this check?	This check is payment for the services shown on your next monthly Explanation of Benefits (EOB) statement.
Who is it for?	The check is issued to the subscriber. It is the subscriber's responsibility to pay the provider, along with any amounts not covered by Regence, if not already paid.
What happens next?	Contact the provider if you need to arrange payment. Keep this stub for your records.
Do you have questions?	Call us at 1-888-319-8904. TTY users should call 711. Our hours are 8 a.m to 8 p.m. Monday through Friday. From Oct. 1 through March 31, we are available from 8 a.m. to 8 p.m. seven days a week. Live online chat assistance is also available from 8 a.m to 5 p.m. Monday through Friday. To access online chat log in at www.regence.com and click the Contact Us link.

Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

2057 Commerce Dr
PO Box 1827
Medford OR 97501
www.regence.com

Forwarding Service Requested

47

[redacted]

Plan Subscriber: [redacted]
Subscriber ID:
Group Name:
Group ID:

Check Amount: $200.00
Check Number: 0108407540
Check Date: 04/20/2026

What is this check?	This check is payment for the services shown on your next monthly Explanation of Benefits (EOB) statement.
Who is it for?	The check is issued to the subscriber. It is the subscriber's responsibility to pay the provider, along with any amounts not covered by Regence, if not already paid.
What happens next?	Contact the provider if you need to arrange payment. Keep this stub for your records.
Do you have questions?	Call us at 1-888-319-8904. TTY users should call 711. Our hours are 8 a.m to 8 p.m. Monday through Friday. From Oct. 1 through March 31, we are available from 8 a.m. to 8 p.m. seven days a week. Live online chat assistance is also available from 8 a.m to 5 p.m. Monday through Friday. To access online chat log in at www.regence.com and click the Contact Us link.

Regence

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2057 Commerce Dr
PO Box 1827
Medford OR 97501
www.regence.com

Forwarding Service Requested

47

[redacted]

Plan Subscriber: [redacted]
Subscriber ID:
Group Name:
Group ID:

Check Amount: $200.00
Check Number: 0108407541
Check Date: 04/20/2026

What is this check?	This check is payment for the services shown on your next monthly Explanation of Benefits (EOB) statement.
Who is it for?	The check is issued to the subscriber. It is the subscriber's responsibility to pay the provider, along with any amounts not covered by Regence, if not already paid.
What happens next?	Contact the provider if you need to arrange payment. Keep this stub for your records.
Do you have questions?	Call us at 1-888-319-8904. TTY users should call 711. Our hours are 8 a.m to 8 p.m. Monday through Friday. From Oct. 1 through March 31, we are available from 8 a.m. to 8 p.m. seven days a week. Live online chat assistance is also available from 8 a.m to 5 p.m. Monday through Friday. To access online chat log in at www.regence.com and click the Contact Us link.

From: [redacted]
[redacted] Form - [redacted]
Date: Monday, May 4, 2026 2:15:25 PM
Attachments: [redacted]

Hi Kristi,
The LEOFF1 Claims form and EOBs from Regence showing they paid for 6 Massage Treatments are attached.
As previously noted by Regence they only allow for 6 massage treatments a year and is verified in our own 2026 Retiree Group Summary of Benefits.
The attached Claims Form is for visits seven and eight which occurred in April 2026.
Please call me if you have any questions.

[redacted]

LEOFF I – CERTIFICATION CLAIM FORM – FIRE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Fire Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [✓] Other [ ] _____

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
1-5-26	Heart Disease	Inland Imaging	116.37	
3-16-26	Heart Disease (Tirzepatide)	Gifthealth - Lilly Dir.	299.00	

TOTAL: $ 415.37

[redacted] [redacted] 3/31/2026

Print Name Date

Board Use Only

RECEIVED

FIRE MEMBER #28

THIS IS A BILL
INLAND IMAGING ASSOCIATES PS

PATIENT [redacted]
ACCOUNT [redacted]
STATEMENT DATE 02/23/2026

00001

BILL SUMMARY

Total Payment Due
Your balance due is:
$116.37

Payment Due By:
03/25/2026

Mobile Pay [redacted]

Pay Online pay.imaginepay.com/provider/IRADAPS
please have your account number (above) ready

Pay By Mail Send in your check along with the payment coupon below.

Have questions about your bill?
Need to set up a payment plan?
Call us at 509-891-0209 M-F 8-5 pm PST

DATE	CPT – SERVICE DESCRIPTION	CHARGES	PAYMENTS	ADJUSTMENTS	PATIENT BALANCE
01/05/26	93880 - 26 EXTRACRANIAL BILAT STUDY Location of Service: KADLEC REGIONAL MEDICAL CTR	$152.00			$116.37
02/06/26	BLUE CROSS MED ADVANTAGE CONTRACTUAL ADJUSTMENT		$35.63	$116.37	
02/23/26	BLUE CROSS MED ADVANTAGE CLAIM DENIED CONSIDERED NOT MEDICALLY NECESSARY				
02/23/26	BLUE CROSS MED ADVANTAGE CONTRACTUAL ADJUSTMENT		$35.63–	$116.37–	
02/23/26	BLUE CROSS MED ADVANTAGE		$35.63		
	Total Due:				$116.37

DETACH HERE AND RETURN THE BOTTOM PORTION WITH YOUR PAYMENT USING THE ENCLOSED ENVELOPE

☐ Has your personal or insurance information changed?
Please check this box and indicate any changes on the reverse side

INLAND IMAGING ASSOCIATES PS
PO BOX 1676
EVANSVILLE IN 47706-0077

Thank you for choosing INLAND IMAGING ASSOCIATES PS

To update your insurance, visit our website: pay.imaginepay.com/provider/IRADAPS or on the back of this statement. If you have concerns about paying your balance, contact us to discuss payment options.

STATEMENT DATE	ACCOUNT	PAY THIS AMOUNT	AMOUNT PAID
02/23/2026	[redacted]	$116.37	

[redacted]

MAKE CHECK PAYABLE AND REMIT TO

INLAND IMAGING ASSOCIATES PS
PO BOX 1676
EVANSVILLE IN 47706-0077

Order Summary

[redacted]

Created 03/13/26 09:19:25 AM

Prescribed by Saba Razi

NPI: 1891675724

ZEPBOUND 2.5 MG/0.5ML SUBCUTANEOUS SOLUTION VIAL (2.5MG)	$299.00

NDC: 00002015204

Rx# [redacted]

Fill Date: March 16th, 2026 11:02

Tax	$0.00
Subtotal	$299.00

LEOFF I – CERTIFICATION CLAIM FORM – FIRE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Fire Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [X] Other [ ] _____

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
4-6-26	Heart Disease Zepbound	Lilly Direct.	304.00	-0-
4-29-26	Heart Disease Zepbound	Lilly Direct.	304.00	-0-

TOTAL: 608.00

[redacted] [redacted] May 11 2026

Print Name Signature Date

Board Use Only

RECEIVED 4/12/26
FIRE Member #28

Lilly Direct®

Thank you for your order!

We've received your payment and your order is being prepared for delivery. While you wait for your prescription, visit this page for resources on how to store the product once it arrives.

Order Summary

[redacted]

Created 04/29/26 10:17:51 AM
Prescribed by Saba Razi
NPI: 1891675724

ZEPBOUND 2.5MG/DOSE (10MG/2.4ML) KWIKPEN (2.5MG) NDC: 00002356611 Rx# [redacted]	$299.00
INJECTION SUPPLIES - PEN NEEDLES	$5.00
Tax	$0.00
Subtotal	$304.00
Total Paid Card ending in [redacted]	$304.00

Lilly Direct®

Thank you for your order!

We've received your payment and your order is being prepared for delivery. While you wait for your prescription, visit this page for resources on how to store the product once it arrives.

Order Summary

[redacted]

Created 04/06/26 01:26:57 PM
Prescribed by Saba Razi
NPI: 1891675724

ZEPBOUND 2.5MG/DOSE (10MG/2.4ML) KWIKPEN (2.5MG) NDC: 00002356611 Rx# [redacted] Fill Date: April 7th, 2026 11:44	$299.00
INJECTION SUPPLIES - PEN NEEDLES	$5.00
Tax	$0.00
Subtotal	$304.00
Total Paid	$304.00

Media Information

[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Regence

NOTICE OF DENIAL OF MEDICARE PART D DRUG COVERAGE

Date: 03/10/2026

Enrollee Name: [redacted]

Member Number: [redacted]

Coverage of your drug was denied
We denied coverage under Medicare Part D for the following drug(s) you or your prescribing provider asked for: ZEPBOUND 2.5MG/0.5ML SOLUTION AUTO-INJECTOR

Why was coverage for this drug denied?
We denied coverage for this drug because:

Drug-Dosage-Strength	Request Type	Outcome
Zepbound Subcutaneous Solution Auto-Injector 2.5 MG/0.5ML	Part D Eligibility	Denied

Medicare Part D rules limit coverage of drugs. They limit it to those that are being used for a Part D eligible medically accepted condition. These rules are found in the Medicare Prescription Drug Benefit Manual, Chapter 6 Section 10.6. Medically accepted conditions are based on Food and Drug Administration (FDA) labeling for this drug.

Drug-Dosage-Strength	Request Type	Outcome
Zepbound Subcutaneous Solution Auto-Injector 2.5 MG/0.5ML	Formulary Exception	Denied

This request for coverage was based on our Formulary Exception criteria. It cannot be approved at this time. You must meet our criteria for this drug to be covered by your plan.

You must have a Food and Drug Administration (FDA) approved diagnosis for the requested drug. Please note, the requested drug is excluded and cannot be covered when used for weight loss only. It is also not covered for uses that are not approved by the FDA. This is based on Medicare rules.

Form CMS-10145 OMB Approval Number 0938-0975 (Expires: 11/30/2027)

LEOFF I – CERTIFICATION CLAIM FORM – Police

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [ ] _____

Date of Service	Condition or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
4-15-26	chronic back pain XTAMPZA ER 9 mg	Richland Rx	452.61	452.61
4-15-26	GNP Naloxone HCL 4MG	Richland Rx	unk	43.83

TOTAL: 496.44

[redacted] [redacted]
Signature

4-15-26
Date

Board Use Only

RECEIVED 4/17/26

April 15, 2026

TO: Kennewick Disability Board
RE: Attached Pharmacy Billings

Dear Board Members;

On this date I saw my pain specialist, Dennis Ang at Apex Spine due to chronic spinal pain. PA Ang has treated me for this condition for approximately three years, and it has continued to worsen to the point where I will be undergoing spinal surgery with Dr. Sahota from Apex this Fall.

During the course of this appointment with PA Ang, he adjusted my medication to include two of the Xtampza pain pills, while reducing one of my other ones (I'm also on hydrocodone). As I noted in a previous submission, Regence refuses to cover the cost of this medication strictly due to economic reasons and they're insisting I consent to taking less expensive medications that are dangerous and highly addictive (as noted in my submission dated April 14th).

If reimbursement is approved, I will be requiring this medication every month until after my surgery, at which time I'm hopeful I'll be able to get off all pain meds.

The other prescription Regence refused to pay for was for something called GNP Naloxone (see attached). This is essentially Narcan & PA Ang is apparently required to prescribe this (once) when his patient (me) reaches a certain amount of prescribed pain medication (opiates). The Richland RX pharmacist advised me that Regence refused to cover the cost because this medication is now available over the counter. The pharmacist at Richland RX told me the $43.83 charge on the Naloxone was not full price and that they had a coupon there that was applied so the price was reduced. I have also shopped around for the best price on Xtampza and found no cheaper price on it anywhere, even through using Good RX.

All submitted for your consideration for reimbursement.

Thank you,

[redacted]

Rx Pharmacy
800 Swift Blvd Ste 140
Richland, WA 99352-3559
Phone: (509) 713-7444
Fax: (509) 713-7422

Apr 15 2026 1:14PM
Receipt [redacted]
Cashier: Samantha R
Drawer #: POS01 - 25857

[redacted] [redacted]
0.00 F
0.00 F
0.00 F
Rx OTC [redacted] 43.83 F
[redacted] [redacted]

Subtotal 129.13
Tax Total 0.00
Items:6 Total 129.13

Visa Tendered 129.13
Acct #: [redacted]
Approval #: [redacted]

F = FLEX/FSA/HRA Eligible
FSA Eligible $129.13

Signature required for the following:
- Payment(s) require a signature
- Receipt of Prescriptions

[redacted]
Signature Captured Electronically

I agree to pay above total amount according to card issuer agreement.

MID: [redacted]
Entry: TAP

[redacted]

Rx Pharmacy
800 Swift Blvd Ste 140
Richland, WA 99352-3559
Phone: (509) 713-7444
Fax: (509) 713-7422

Apr 15 2026 3:43PM
Receipt # [redacted]
Cashier: Estella V
Drawer #: POS01 - 25857

Rx [redacted] 452.61 F

Subtotal	452.61
Tax Tota	0.00
# Items:1 Total	452.61

Visa Tendered 452.61
Acct #: [redacted]
Approval #: [redacted]

F = FLEX/FSA/HRA Eligible
FSA Eligible $452.61

Prescription(s) picked up by: [redacted]

Signature required for the following:
- Payment(s) require a signature
- Receipt of Prescriptions

[redacted]

Signature Captured Electronically

I agree to pay above total amount according to card issuer agreement.

MID: [redacted]
Entry: TAP

[redacted]

Scan This QR Code for Patient Specific Medication Information

Claim Summary EDI Sent EDI Received Compare Previously Paid Claim

Partner Network

Transmitted Date: 4/15/2026 9:14:59 AM
Pay Method: Bc/bs Oregon Pdp
Rx Number: [redacted]
Help Desk Phone: (888) 869-4600
Third Party Phone: (888) 869-4600
Third Party Website:

	Submitted	Paid
Base:	$105.60	$0.00
Fee:	$11.00	$0.00
Subtotal:	$116.60	$0.00
Tax:	$0.00	$0.00
Total:	$116.60	$0.00
Copay:		$0.00

Patient

Patient: [redacted]
Birthday:
Gender:
CardHolder ID:
Relationship: Cardholder
Group ID: [redacted]

Prescriber

Prescriber: Ang
NPI: 1184830432
DEA: MA1441598

Rx Information

Rx Item: Naloxone Hcl 4 Mg Nasal Spray
Days Supply: 1
PA: 0
NDC: 68001064545
DAW: 0
Authorization: [redacted]

Message

Info - Get information about the prescription

Rejected: A5. This medication reject may be able to be resolved without a PA. If required, please start a PA.

Reject Codes — Check UGO For Alternatives

Explanation	Possible Error
Not Covered Under Part D Law	Date Filled (D1), Cardholder ID (C2), Dispensed Product ID (D7)

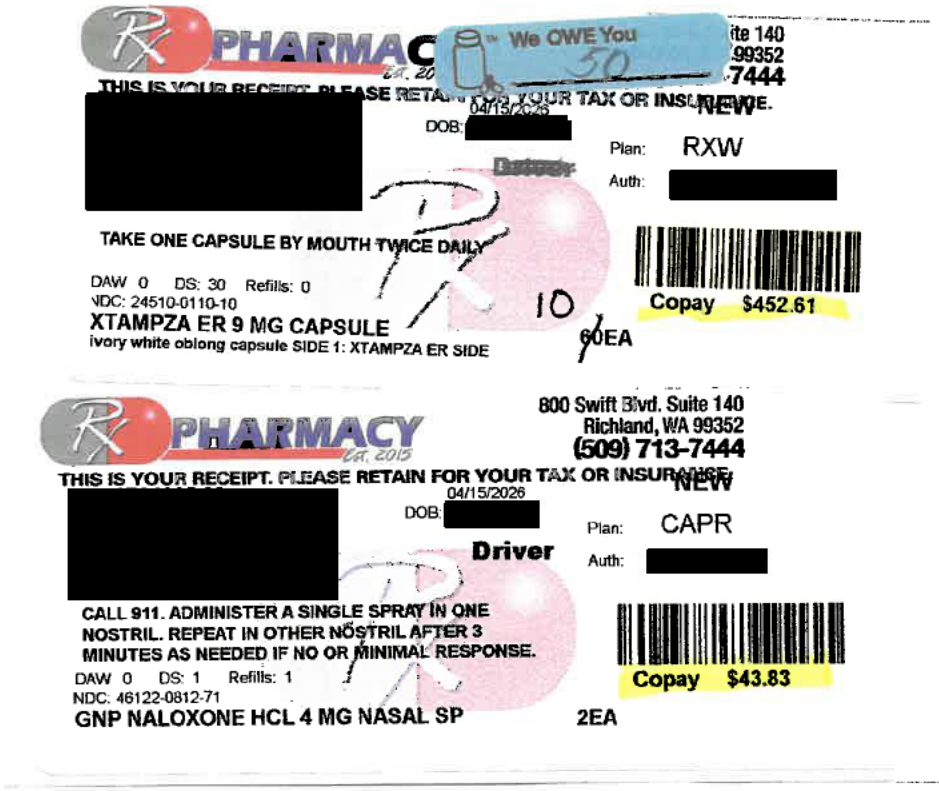
DUR Response Messages

Reason For Service Code	Free Text Message	Clinical Significance	Previous Date Of Fill	Quantity Of Previous Fill

Prior Authorization Code: [illegible] - Not Specified — Number: — This Fill
Submission Clarification Code: 0 = Not Specified — This Fill
Product ID Qualification: 00 = Not Specified — This Fill
Other Coverage Code: [illegible] = Not Specified — This Fill
Level of Service Code: [illegible] = Not Specified — This Fill
Incentive Amount: 0.00 — This Fill
DUR Scope: This Fill

Reason for Service	Professional Service	Result of Service	Level Of Effort

Start PA - F2 | Print Claim - F3 | RxChange Request - F4 | Future Fill - F5 | Print Reject - F7 | Medicare Rights - F8 | Close - ESC



PHARMACY
Est. 2015

We OWE You 30

ite 140
.99352
.7444

THIS IS YOUR RECEIPT. PLEASE RETA[illegible] FOR YOUR TAX OR INSU[illegible]E.

04/15/2026

NEW

[redacted]

DOB: [redacted]

Plan: RXW

Auth: [redacted]

Delivery

TAKE ONE CAPSULE BY MOUTH TWICE DAILY

DAW 0 DS: 30 Refills: 0

NDC: 24510-0110-10

XTAMPZA ER 9 MG CAPSULE

ivory white oblong capsule SIDE 1: XTAMPZA ER SIDE

10

60EA

Copay $452.61

PHARMACY
Est. 2015

800 Swift Blvd. Suite 140
Richland, WA 99352
(509) 713-7444

THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

04/15/2026

NEW

[redacted]

DOB: [redacted]

Plan: CAPR

Auth: [redacted]

Driver

CALL 911. ADMINISTER A SINGLE SPRAY IN ONE NOSTRIL. REPEAT IN OTHER NOSTRIL AFTER 3 MINUTES AS NEEDED IF NO OR MINIMAL RESPONSE.

DAW 0 DS: 1 Refills: 1

NDC: 46122-0812-71

GNP NALOXONE HCL 4 MG NASAL SP

2EA

Copay $43.83

LEOFF I – CERTIFICATION CLAIM FORM – Police

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits;** and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [ ] _____

Date of Service	Condition or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
3/16/26	Chronic Back Pain	Apex Spine Richland, Rx Pharmacy	$ 227.93	$ 227.93
11/19/25	Corrective Eye Wear	Family Eye Care	186.80	$ 186.80

TOTAL: $ ~~227.93~~ 414.73

[redacted] [redacted] 4/14/26

Print Name Signature Date

Board Use Only

RECEIVED 4/17/26

April 14, 2026

TO: Kennewick Disability Board
RE: Family Eye Care Eye Glasses Billing
Richland RX Prescription Medication Denial

Dear Board Members;

Attached, you will find (1) an invoice from Family Eye Care in the amount of $186.80 which reflects the amount not covered by our insurance after the purchase of a pair of glasses last November. The glasses were purchased but were not suitable so I returned them, only to learn that I needed to have laser treatment for cataracts that had returned. This was accomplished in March so I returned to Family Eye Care for a corrected pair of glasses. Those didn't correct the problem so I'm now waiting for the third pair to arrive (which explains the delay in getting the bill submitted). As you're aware, our insurance company doesn't send us EOB's when glasses are purchased, thus none is attached.

The second submission is for a prescription for a pain medication called Xtampza, which was prescribed by my pain management PA, Dennis Ang (Apex Spine). I suffer from chronic back pain & will undergo spinal surgery this Fall but until then, PA Ang has suggested (prescribed) this medication to help me sleep and get me through the night. Because it is a bit more expensive than some other pain meds, our insurance doesn't want to pay for it. They are insisting I try some medications like Fentanyl and Methadone, which both my PA and I feel are too dangerous and far more addictive than the Xtampza. I appealed this decision (twice) and had my PA appeal it but Regence still refuses to cover the cost of this medication.

Please review the submitted information for your consideration of reimbursement.

Thank you,

[redacted]

Invoice

Send payments to:
Family Eye Care 7903 W. Grandridge Blvd Ste A Kennewick WA 993367827 (509) 783-0667

Service Date	Invoice Date	Invoice #
11/19/2025	11/19/2025	[redacted]

Patient	Patient #
[redacted]	[redacted]

Provider	Tax ID
Robertson, Boyd OD	911173133

Bill To
[redacted]

Code	Description	Price	Qty	Disc	Tax	Adjs	Paid	Balance
V2020	Luxottica RX6421 Diagnoses: H52.223	$216.00	1	$0.00	$0.00	-$203.2	$0.00	$12.80
	Billed to Insurance - Invoice [redacted] ($216.00)							
	Transfer In - PR-3 Copay : $12.80							
V2100	Hoya (SmartFlow) My-SV Diagnoses: H52.223	$72.50	1	$0.00	$0.00	-$50.00	$0.00	$22.50
	Billed to Insurance - Invoice [redacted] ($72.50)							
	Transfer In - PR-3 Copay : $22.50							
V2100	Hoya (SmartFlow) My-SV Diagnoses: H52.223	$72.50	1	$0.00	$0.00	-$50.00	$0.00	$22.50
	Billed to Insurance - Invoice [redacted] ($72.50)							
	Transfer In - PR-3 Copay : $22.50							
V2750	Hoya Vision Care EX3+ Diagnoses: H52.223	$150.00	1	$0.00	$0.00	-$49.00	$0.00	$101.00
	Billed to Insurance - Invoice [redacted] ($150.00)							
	Transfer In - PR-3 Copay : $101.00							
V2782	Lab Supplied Trivex Diagnoses: H52.223	$80.00	1	$0.00	$0.00	-$52.00	$0.00	$28.00
	Billed to Insurance - Invoice [redacted] ($80.00)							
	Transfer In - PR-3 Copay : $28.00							
PAYMENT	Credit Card (Visa) - 11/20/2025							-$186.80

PHARMACY

800 Swift Blvd. Suite 140
Richland, WA 99352
(509) 713-7444

THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

Rx: [redacted] NEW

DOB: [redacted] 03/16/2026

Plan: RXW

Auth: [redacted]

314 S JEFFERSON ST
KENNEWICK, WA 99336-9308
(509) 947-5987

Driver

TAKE ONE CAPSULE BY MOUTH EVERY EVENING

DAW 0 DS: 30 Refills: 0
NDC: 24510-0110-10

XTAMPZA ER 9 MG CAPSULE 30EA
Ivory white oblong capsule SIDE 1: XTAMPZA ER SIDE

Copay $227.93

Delivery Address:

Name: [redacted]
Address:
Phone:

No A/R Account

Rx Pharmacy
800 Swift Blvd Ste 140
Richland, WA 99352-3559
Phone: (509) 713-7444
Fax: (509) 713-7422

Mar 17 2026 9:21AM
Receipt # [redacted]
Cashier: santiago g
Drawer #: POS03 - 25544

Rx [redacted] 227.93 F
[redacted]

Subtotal	227.93
Tax Total	0.00
# Items:1 Total	227.93

Visa Tendered 227.93
Acct #: [redacted]
Approval #: [redacted]

F = FLEX/FSA/HRA Eligible
FSA Eligible $227.93

Signature required for the following:
- Payment(s) require a signature
- Receipt of Prescriptions
- Receipt of Delivered Goods

Signature

I agree to pay above total amount according to card issuer agreement.

MID: [redacted]
Entry:

[redacted]

[redacted] RPh: JRM-kap 3/16/2026 2:54:15 PM

Prescriber: DENNIS ANG APNP Prescriber Phone: (509) 606-5040

** **REJECTED - N0700012 00**

30.00000 24510011010 XTAMPZA ER 9 MG CAPSULE

Extended Message

Reject Reason(s)

MR	Product Not On Formulary
569	Provide Notice: Medicare Prescription Drug Coverage and Your Rights

DUR Messages

Reason Code	Previous Fill	Previous Quantity	Message
LD			GERIATRIC MIN DLY=2 CAPSULE

Patient: [redacted] DOB: [redacted]

Pay Plan: BC/BS OREGON PDP (888) 869-4600

Relation: Cardholder

Group: [redacted]

Card ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Regence

NOTICE OF DENIAL OF MEDICARE PART D DRUG COVERAGE

Date: 03/17/2026

Enrollee Name: [redacted]

Member Number: [redacted]

Coverage of your drug was denied

We denied coverage under Medicare Part D for the following drug(s) you or your prescribing provider asked for: XTAMPZA ER 9MG CAPSULE ER 12 HOUR ABUSE-DETERRENT

Why was coverage for this drug denied?

We denied coverage for this drug because:

Drug-Dosage-Strength	Request Type	Outcome
Xtampza ER Oral Capsule ER 12 Hour Abuse-Deterrent 9 MG	Formulary Exception	Denied

This request for coverage was based on our Formulary Exception criteria. It cannot be approved at this time. You must meet our criteria for this drug to be covered by your plan.

- You must try and fail 1 additional drug for your condition covered by your prescription drug plan. You may not have to try the covered drugs if your prescriber provides information that shows why they are not right for you. Drugs that may be covered are listed below. Drugs listed with an asterisk (*) may need prior authorization. If a drug requires prior authorization, please visit your drug plan's website to request coverage. You may also call the number on the back of your insurance card.

- buprenorphine patch
- fentanyl patch*
- methadone (tablet, oral solution)
- tramadol extended-release tablet* (generic Ultram ER)

Model Redetermination Notice of Denial of Medicare Drug Coverage

Date: 03/25/2026
Enrollee name: [redacted]
[redacted]
Plan Name: Regence MedAdvantage + Rx (PPO)
Formulary ID: [redacted]

Enrollee ID Number: [redacted]
Contract ID: [redacted]
Plan ID: [redacted]

This notice is to let you know we agree with our initial coverage determination: we're denying coverage for the following prescription drug(s) that you, your doctor, or prescriber asked for: XTAMPZA ER 9MG CAPSULE ER 12 HOUR ABUSE-DETERRENT

We're denying coverage because:

Drug-Dosage-Strength	Request Type	Outcome
Xtampza ER Oral Capsule ER 12 Hour Abuse-Deterrent 9 MG	Formulary Exception	Denied

This request for coverage was based on our Formulary Exception criteria. It cannot be approved at this time. You must meet our criteria for this drug to be covered by your plan.

- You must try and fail 1 additional drug for your condition covered by your prescription drug plan. You may not have to try the covered drugs if your prescriber provides information that shows why they are not right for you. Drugs that may be covered are listed below. Drugs listed with an asterisk (*) may need prior authorization. If a drug requires prior authorization, please visit your drug plan's website to request coverage. You may also call the number on the back of your insurance card.

- buprenorphine patch
- fentanyl patch*
- methadone (tablet, oral solution)
- tramadol extended-release tablet* (generic Ultram ER)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Regence

NOTICE OF DENIAL OF MEDICARE PART D DRUG COVERAGE

Date: 04/06/2026

Enrollee Name: [redacted]

Member Number: [redacted]

Coverage of your drug was denied

We denied coverage under Medicare Part D for the following drug(s) you or your prescribing provider asked for: XTAMPZA ER 9MG CAPSULE ER 12 HOUR ABUSE-DETERRENT (03/16/2026)

Why was coverage for this drug denied?

We denied coverage for this drug because:

Your prescriber has shared supporting information; but you do not meet the following requirements for your health plan to approve this request.

Drug-Dosage-Strength	Request Type	Outcome
Xtampza ER Oral Capsule ER 12 Hour Abuse-Deterrent 9 MG	Payment Review	Denied

This request for payment cannot be approved at this time based on Medicare rules for Reimbursement Requests. These rules are found in Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Section 40.2 - Part D Coverage Determinations and Section 50.8 Service or Benefit Received Prior to Notice of Decision.

A review of your drug was completed, and a denial letter was mailed to you. This letter contains detailed information about why your drug cannot be approved under the current Medicare guidelines. As a result, we are unable to approve your request for reimbursement. You have the right to appeal. Instructions for filing an appeal are included in the denial letter.

LEOFF I – CERTIFICATION CLAIM FORM – FIRE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Fire Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [ ] _____

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
2/2/2026	EMS Transport	City of Kennewick	1015.50	415.49

TOTAL: 1015.50 415.49

[redacted] [redacted] 5-14-26

Print Name **Signature** **Date**

Board Use Only

FIRE MEMBER #21
RC'D 5.14.26

[redacted]

CITY OF KENNEWICK Claim Number: [redacted] Out-of-network provider	Date of Service	Amount the providers billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
Ambulance service, basic life support, emergency transport (bls-emergency)(billing code A0429RH) Pricing for services based on maximum allowed amount for this provider type.	2/2/2026	$810.00	$481.63	$481.63	$0.00
Ground mileage, per statute mile(billing code A0425RH) Pricing for services based on maximum allowed amount for this provider type.	2/2/2026	$205.50	$130.62	$130.62	$0.00
	TOTALS:	$1,015.50	$612.25	$612.25	$0.00

City of Kennewick
C/O Billing Services
PO Box 3510
Silverdale, WA 98383-3510

Billing Phone: (800) 238-9398
Billing Fax: (360) 394-7098
Billing Email: kennewick@emspatient.com
www.emspatient.com/kennewick

AMBULANCE SERVICES STATEMENT

Patient: [redacted]

Patient #: [redacted]

INSURANCE INFO:
Primary: Premera Blue Card Medadvantage

IMPORTANT MESSAGE:

Date of Service	Transport ID Number	Charges	Payments	Discounts	Balance
02/02/26	[redacted]	$1,015.50	($600.01)	$0.00	$415.49

Last Payment Date: 4/28/2026

For more information, or to make a payment online, visit our web site at www.emspatient.com/kennewick. Translation services available.

Current	31-60	61-90	91-120	Over 120
$415.49	$0.00	$0.00	$0.00	$0.00

CURRENT BALANCE: $415.49
PLEASE PAY THIS AMOUNT => $415.49

DETACH ALONG LINE AND RETURN STUB WITH YOUR PAYMENT. THANK YOU

1 of 1

City of Kennewick
C/O Billing Services
PO Box 3510
Silverdale, WA 98383-3510
RETURN SERVICE REQUESTED

IF PAYING BY VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS, FILL OUT BELOW

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMER. EXP.

CARD NUMBER	EXP. DATE	AMOUNT
NAME ON CARD	MUST INCLUDE 3 OR 4 DIGIT SECURITY CODE FROM FRONT (AMER. EXP.) OR BACK OF CARD	

STATEMENT DATE	PATIENT ID	PAY THIS AMOUNT
4/30/2026	[redacted]	$415.49

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT

SHOW AMOUNT PAID HERE $

158662 - 421

0007 002773 [redacted]

REMIT TO:

City of Kennewick
C/O BILLING SERVICES
PO BOX 3510
SILVERDALE WA 98383-3510

LEOFF I – CERTIFICATION CLAIM FORM – FIRE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Fire Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [ ] _____

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
2/2/26 – 2/15/26	In-Home Healthcare	Solutions In Home Care	5586.57	5586.57
		TOTAL:	5586.57	5586.57

[redacted] [redacted] 2-26-26

Print Name **Signature** **Date**

Board Use Only

Board paid (Feb 2026)

LEOFF I – CERTIFICATION CLAIM FORM – FIRE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Fire Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [ ] _____

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
2/16/26 – 2/23/26	In-Home Healthcare	Solutions In-Home Care	8576.44	8576.44
		TOTAL:	8576.44	8576.44

[redacted] [redacted] 2-26-26

Print Name Signature Date

Board Use Only

Board paid $1,849.43 to reach limit $7436/mo.
$6,727.01 remaining – still working with Ins.

kristi.mbc@live.com

From: Kristi Smith <Kristi.Smith@ci.kennewick.wa.us>
Sent: Monday, May 18, 2026 2:21 PM
To: kristi.mbc@live.com

[redacted]

Good afternoon,

I'm sorry for the delay I need to check with my claims department on the coding part. In the meantime, I have communicated with the provider and they advised they are happy to help provide what is needed. They do need the request in writing, and I am not able to do that. I communicated with Matt S. with Solutions in Home care at 509-627-8575 and he referred me to communicate with Haley their billing specialist Monday-Thursday if you want to pass the information to the daughter so they can help her get what is needed.

The written request of what is needed can be sent to the following emails-

Haley@solutionsinhomecare.com

Matt@solutionsinhomecare.com

The following is needed currently-

- Service/CPT/HCPCS code(s) and/or description(s)
- Units
- Diagnosis code(s) and/or description(s)
- Provider NPI

Thank you,

Flor Patterson

Medicare Customer Service Ambassador

(800) 541-8981 Ext: 6572

M-F 7 A.M-4 P.M

Solutions In-Home Care
509-627-8575
7401 W Hood Pl. Suite 204
Kennewick, WA 99336

INVOICE

Balance Due $8,576.44
Due Date 03/06/26

Bill To

[redacted]

Invoice #	[redacted]
Date	03/01/26
Status	Unpaid
Service From	02/16/26
To	02/23/26
Client	[redacted]
Insurance Policy #	Tax ID 900770219 Home Health Aide S9122
Total Hours	180.37

Description	Type	Quantity	Rate	Amount
02/16/26 (Mon) @ 12:00am - 7:24am - CG: Bryanna (Level 4)	Hours Normal	7.4	$50.00	$370.00
Care Coordination Service fee (semimonthly)	Expense	1	$75.00	$75.00
02/16/26 (Mon) @ 7:00am - 3:14pm - CG: Alexia (Level 4)	Hours Normal	8.2333	$46.00	$378.73
02/16/26 (Mon) @ 2:57pm - 11:12pm - CG: Raquel (Level 4)	Hours Normal	8.25	$46.00	$379.50
02/16/26 (Mon) @ 10:53pm - 12:00am - CG: Bryanna (Level 4)	Hours Normal	1.1167	$46.00	$51.37
02/17/26 (Tue) @ 12:00am - 7:18am - CG: Bryanna (Level 4)	Hours Normal	7.3	$46.00	$335.80
02/17/26 (Tue) @ 7:08am - 3:02pm - CG: Alexia (Level 4)	Hours Normal	7.9	$46.00	$363.40
02/17/26 (Tue) @ 2:56pm - 11:17pm - CG: Raquel (Level 4)	Hours Normal	8.35	$46.00	$384.10
02/17/26 (Tue) @ 10:57pm - 12:00am - CG: Bryanna (Level 4)	Hours Normal	1.05	$46.00	$48.30
02/18/26 (Wed) @ 12:00am - 7:14am - CG: Bryanna (Level 4)	Hours Normal	7.2333	$46.00	$332.73
02/18/26 (Wed) @ 6:55am - 3:08pm - CG: Alexia (Level 4)	Hours Normal	8.2167	$46.00	$377.97
02/18/26 (Wed) @ 1:00pm - 2:45pm - CG: Dulce (Care Coordination)	Hours Normal	1.75	$50.00	$87.50
02/18/26 (Wed) @ 3:00pm - 11:19pm - CG: Nicole (Level 4)	Hours Normal	8.3167	$46.00	$382.57
02/18/26 (Wed) @ 11:03pm - 12:00am - CG: Bryanna (Level 4)	Hours Normal	0.95	$46.00	$43.70
02/19/26 (Thu) @ 12:00am - 7:11am - CG: Bryanna (Level 4)	Hours Normal	7.1833	$46.00	$330.43
02/19/26 (Thu) @ 7:01am - 3:08pm - CG: Alexia (Level 4)	Hours Normal	8.1167	$46.00	$373.37
02/19/26 (Thu) @ 2:53pm - 11:08pm - CG: Nicole (Level 4)	Hours Normal	8.25	$46.00	$379.50
02/19/26 (Thu) @ 10:56pm - 12:00am - CG: Xochitl \\"So-Chill"\\ - PRN (Level 4)	Hours Normal	1.0667	$46.00	$49.07
02/20/26 (Fri) @ 12:00am - 7:02am - CG: Xochitl \\"So-Chill"\\ - PRN (Level 4)	Hours Normal	7.0333	$46.00	$323.53
02/20/26 (Fri) @ 7:00am - 3:01pm - CG: Alexia (Level 4)	Hours Normal	8.0167	$46.00	$368.77

Description	Type	Quantity	Rate	Amount
02/20/26 (Fri) @ 12:00pm - 2:00pm - CG: Dulce (Care Coordination)	Hours Normal	2	$50.00	$100.00
02/20/26 (Fri) @ 2:55pm - 9:06pm - CG: Kimberly (Level 4)	Hours Normal	6.1833	$46.00	$284.43
02/20/26 (Fri) @ 8:56pm - 12:00am - CG: Xochitl \\"So-Chill"\\ - PRN (Level 4)	Hours Normal	3.0667	$50.00	$153.34
02/21/26 (Sat) @ 12:00am - 7:01am - CG: Xochitl \\"So-Chill"\\ - PRN (Level 4)	Hours Normal	7.0167	$50.00	$350.84
02/21/26 (Sat) @ 6:58am - 3:04pm - CG: Lara (Level 2)	Hours Normal	8.1	$46.00	$372.60
02/21/26 (Sat) @ 2:56pm - 11:18pm - CG: Adriana (Level 2)	Hours Normal	8.3667	$46.00	$384.87
02/21/26 (Sat) @ 8:00pm - 8:45pm - CG: Dulce (Care Coordination)	Hours Normal	0.75	$50.00	$37.50
02/21/26 (Sat) @ 10:56pm - 12:00am - CG: Emmerson (Level 4)	Hours Normal	1.0667	$50.00	$53.34
02/22/26 (Sun) @ 12:00am - 7:07am - CG: Emmerson (Level 4)	Hours Normal	7.1167	$50.00	$355.84
02/22/26 (Sun) @ 6:54am - 6:57pm - CG: Lara (Level 4)	Hours Normal	12.05	$50.00	$602.50
02/22/26 (Sun) @ 6:55pm - 11:28pm - CG: Adriana (Level 4)	Hours Normal	4.55	$50.00	$227.50
02/22/26 (Sun) @ 8:00pm - 8:45pm - CG: Dulce (Care Coordination)	Hours Normal	0.75	$50.00	$37.50
02/22/26 (Sun) @ 10:56pm - 12:00am - CG: Emmerson (Level 4)	Hours Normal	1.0667	$50.00	$53.34
02/23/26 (Mon) @ 12:00am - 2:33am - CG: Emmerson (Level 4)	Hours Normal	2.55	$50.00	$127.50
		Total		**$8,576.44**

Memo:
Thank you for choosing Solutions In-Home Care!

Applied Payments & Credits

Date	Type	Amount
There are no applied payments or credits for this invoice		

AMOUNT DUE ON THIS INVOICE:
$8,576.44

Notice of Denial of Payment

Date: April 7, 2026

Member number: [redacted]
Claim number:

Name: [redacted]

Provider: Payee Member
[redacted]

Coverage for your medical services/items was denied

We've denied the payment of medical services/items or Medicare Part B drug listed below that you or your provider requested:

Claim Line	Date of Service	Type of Service	Charge	Denial Code
1	02/02/2026		$14,163.01	B16

Why was coverage denied?

We denied the payment of medical services/items or Medicare Part B drug listed above because:

Denial Code	Denial Explanation
B16	Please resubmit claim with an itemized invoice. The receipt/EOB previously submitted was insufficient or not legible for processing

Share a copy of this decision with your provider and discuss next steps. If your provider asked for coverage on your behalf, we already sent them a copy of this denial notice.

You have the right to appeal our decision

You have the right to ask Regence MedAdvantage to review our decision by asking us for an appeal within **65 calendar days** of the date of this notice. If you ask for an appeal after 65 days, you must explain why your appeal is late. See "How to ask for an appeal with Regence MedAdvantage" on the next page.

How to keep your services while we review your case: If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed. **For service to continue, you must ask for an appeal within 10 days** of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should keep getting the service. You may have to pay for these services if you lose your appeal.

If you want someone else to act for you

You can name a relative, friend, attorney, provider, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-888-319-8904 to learn how to name your representative. TTY users call 711.

Family Leave Certification - Serious Health Condition
Certificado de permiso familiar: condición de salud grave

Washington **Paid Family & Medical Leave**
Employment Security Department

Use this form when taking leave to care for a family member who has a serious health condition.	Use este formulario cuando solicite un permiso para cuidar a un familiar que tenga una condición de salud grave.

SECTION 1: Paid Leave customer information | SECCIÓN 1: Información del cliente del permiso pagado

Name of person applying for family leave* | Nombre de la persona que solicita el permiso familiar *:
Jennifer Ayres

Date of birth (MM/DD/YYYY)* | **Fecha de nacimiento** (MM/DD/YYYY)* : [redacted]	**Paid Leave Customer ID | Identificación de cliente del permiso pagado:** [redacted]

SECTION 2: Health care provider certification | SECCIÓN 2: Certificado del proveedor de atención médica

To be completed and signed by an authorized health care provider.
Complete all required fields (*). Incomplete forms may delay your patient's eligibility for benefits.

Patient's name* : [redacted]	**Patient's Date of birth** (MM/DD/YYYY)* : [redacted]

Briefly describe the serious health condition*. Your answers should be your best estimate based on your medical knowledge, experience, and examination of the patient. Patient is admitted to hospice services with end stage Chronic Obstructive Pulmonary disease with 6 months or less expected lifespan.

Provide the start and end dates for the leave needed due to the serious health condition described above*.
Give specific dates. Terms such as "unknown" or "indeterminate" won't be sufficient to determine Paid Leave eligibility.

Start date (MM/DD/YYYY)* : 2 / 12 / 26 **End date** (MM/DD/YYYY)* : 8 / 12 / 26

I declare under penalty of perjury that the information provided in this form is true and correct, that I have read and understand the definition of a serious health condition, that the patient's condition meets the definition of "serious health condition," and that I am a health care provider authorized to certify their condition (RCW 50A.05.010; WAC 192-500-090).

Signature* : Brandon Thomas Brandon Thomas (Feb 19, 2026 14:40:16 PST)	**Date** (MM/DD/YYYY)* : 2 / 19 / 26

Name and title*: Brandon Thomas, DO

Certificate license number and state: OP0000 2209	**Type of practice/Specialty*** : Hospice
Phone* : 509-783-7416	**Email address** : intake@tcbestlife.org

Business address* : 1480 Fowler St., Richland, WA 99352

The Employment Security Department is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Language assistance services for limited English proficient individuals are available free of charge. Washington Relay Service: 711

From: Haley Lakey <haley@solutionsinhomecare.com>
Sent: Thursday, May 21, 2026 3:47 PM
To: Matt Steltenpohl <matt@solutionsinhomecare.com>; [redacted]
Cc: Kristi Smith <Kristi.Smith@ci.kennewick.wa.us>; [redacted]
Subject: Re: Regence Info Needed

1. Code and Service Description
S9122 is a **per-hour** code for in-home care provided by a home health aide (HHA) or certified nurse assistant (CNA) for activities of daily living (ADLs) such as bathing, dressing, grooming, toileting, medication reminders, light wound care, and vital sign monitoring.

2. Units
It is billed in units (**each unit = 1 hour**) Hours listed are under total hours on the top right of each Solutions Invoice.

3. Diagnosis Code
This would be from his actual Physician. We do not assign these codes, but I can see the following ICD-10 Code's on a document from his Physician. If you want to double check on these please call his Physician to see if there may be more.

J44.1 COPD with (acute) exacerbation
J18.9 Pneumonia
J96.10: Chronic respiratory failure
R06.02 Chronic shortness of breath

4. Provider NPI
HHC Solutions/Solutions In-Home Care 1811383680

Please let me know if you need anything else.

Thanks,
Haley Lakey