### **A DELTA DENTAL**



# A Guide to your Explanation of Benefits

For more information, contact Benefit Services at 800.237.6060.

Payment date — the date the claim was paid.

**B** Dentist/facility — the patient's dentist or dentist's office.

• Dentist ID number — the dentist's ID.

Network status — the participating status of the dentist under the patient's plan.

**Subscriber name** – the name of the subscriber.

**Patient name** – the patient's information.

**6** Account — the group number under the plan.

**Claim number** — the claim number.

**1** Tooth or cavity — the tooth that was serviced, if applicable.

Date of service — the date service was provided to the patient.

• Submitted amount — the amount submitted to Delta Dental by the dentist.

Contract allowance — The contract allowance is calculated based on the amount the dentist has agreed to accept from Delta Dental of Virginia.

#### Ճ DELTA DENTAL<sup>®</sup>

Delta Dental of Virginia 4818 Starkey Road, Roanoke, VA 24018-8510 540-989-8000 • 800-237-6060

Jack Doe 1000 Cool Street Roanoke, VA 24000 GO GREEN! Receive your EOB online in four steps: 1. Log in as a member at DeltaDentalVA.com. 2. Click your name from the top menu. 3. Click Edit Account 4. Fill in your email address, click the box to

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**EXPLANATION OF BENEFITS** 

4. Fill in your email address, click the box to receive email communications and click "save."

	Y Y	A PAYMENT DATE			B DENTIST/FACILITY			DNO. D	NETWORK STAT		
		08/29/2020 SUBSCRIBER NAME			ABC Dentist PATIENT NAME			00000	In-Network		
	E SUI							G ACCOUNT			
	Jack Doe			Jane Doe	000	000000	)1234	123456789000			
TOOTH or CAVITY		PROCEDURE DESCRIPTION	SUBMITTEL AMOUNT	CONTRACT ALLOWANCE	PLAN ALLOWANCE	DEDUCTIBLE	PLAN COINS %	PLAN PAYS	PATIENT PAYS	MESSA CODE(	
4	02-14-2019	INTRAORAL	\$44.00	\$21.00	\$21.00	\$0.00	100%	\$21.00	<b>\$0</b> .00	[1-19]	
4	02-14-2019	ENDODONTI	\$0.00	\$0.00	\$0.00	\$0.00	80%	\$0.00	\$0.00	0	
4	02-14-2019	ENDODONTI	\$1,455.00	\$725.00	\$725.00	\$50.00	80%	\$540.00	\$185.00	[]	
		TOTALS	\$1,499.00	\$746.00	\$746.00	\$50.00		\$561.00	\$185.00		
		EXPLANATIO									
		P	o patient pays.								
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servici amour provid For ind 800-2 mislea Dental at 888	es provided nt filed on y led on those quiries, com 237-6060. If ading or fals I of Virginia 3-227-6004.	of Benefits (I I, the dates o our insuranc e dates. Revi tact Benefit 1 you believe e informatio on our frauc	EOB) lists if services e claim fo ew it for a Services a this EOB n, contact d and abus	the dental and the r services accuracy. It contains Delta se hotline	MAX		ZED TO	DATE	-	.,	
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▶ Plan allowance — the amount the participating dentist agrees to accept based on their participating agreement. If the dentist is out-of-network, this amount is the same as the Submitted Amount.

Continued on next page

#### **A DELTA DENTAL**



## A Guide to your Explanation of Benefits (continued)

• Deductible — the amount of covered services the patient must pay before Delta Dental pays.

Delta Dental of Virginia
 plan co-insurance percentage
 the percentage of the
 Contract Allowance that
 Delta Dental pays.

Delta Dental of Virginia plan pays — the amount paid to the dentist or to you. Payment is made to you only when you visit an out-ofnetwork dentist.

**Patient pays** — the amount the patient owes to the dentist, which includes any deductible, co-insurance, and the difference in the Approved Amount and the Contract Allowance.

S Message code — the code that was used in processing the service.

 Message code explanation

 an explanation of the processing policy codes.

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Jack Doe 1000 Cool Street Roanoke, VA 24000 EXPLANATION OF BENEFITS

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		PAYMENT DATE		DENTIST/FACILITY			DENTIST ID NO.			NETWORK STATUS	
		08/29/2020		ABC Dentist			XX0000000000			In-Network	
	SU	SUBSCRIBER NAME		PATIENT NAME			ACCOUNT			CLAIM NO.	
	Jack Doe			Jane Doe			0000000001234			123450789000	
TOOTH or CAVITY	DATE OF SERVICE	PROCEDURE DESCRIPTION	SUBMITTED AMOUNT	CONTRACT ALLOWANCE	PLAN ALLOWANCE	DEDUCT	TIBLE	PLAN COINS %	PLAN PAYS	PATIENT PAYS	MESSAGE CODE(S)
4	02-14-2019	INTRAORAL	\$44.00	\$21.00	\$21.00	\$0.0	0	100%	\$21.00	\$0.CO	[1-19]
4	02-14-2019	ENDODONTI	\$0.00	\$0.00	\$0.00	\$0.0	0	80%	\$0.00	\$0.00	[]
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		TOTALS	\$1,499.00	\$746.00	\$746.00	\$50.0	20		\$561.00	\$185.00	
MESSA	GE CODE	EXPLANATIO	ON:								
I-19	I-Due to ad	ditional information of the second seco	on, an adjustn potient pays.	ent has been ma	de to a previous	claim pay	ment c	r denial whi	ich may resu	lt in additiona	l co-pay

ORTHODONTIA PAID TO DATE

MAXIMUM UTILIZED TO DATE

DEDUCTIBLE SATISFIED TO DATE

TOTAL PAYMENT 08/29/2020

PATIENT RESPONSIBILITY

\$ 1,380.00

\$ 50.00

\$561.00

\$185.00

This Explanation of Benefits (EOB) lists the dental services provided, the dates of services and the amount filed on your insurance claim for services provided on those dates. Review it for accuracy. For inquiries, contact Benefit Services at 800-237-6060. If you believe this EOB contains misleading or false information, contact Delta Dental of Virginia on our fraud and abuse hotline at 888-227-6004.

Payment for these services is determined in accordance with the terms of your dental plan and the agreement(s) the dentist has with Delta Dental of Virginia (including other Delta Dental member companies). If you disagree with the benefit determination, refer to the back side to review your appeal rights.

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