DELTA DENTAL®

Understanding Your Explanation of Benefits (EOB)

After a trip to the dentist's office, you'll likely receive an EOB from your dental benefits carrier explaining the procedures performed and what is covered by your dental plan.

A

This section contains subscriber and patient identification information, which you'll need to check on a claims status or dispute a claim.

B

The **Procedure Code** and **Procedure Description** explain the services received at the dentist's office.

C

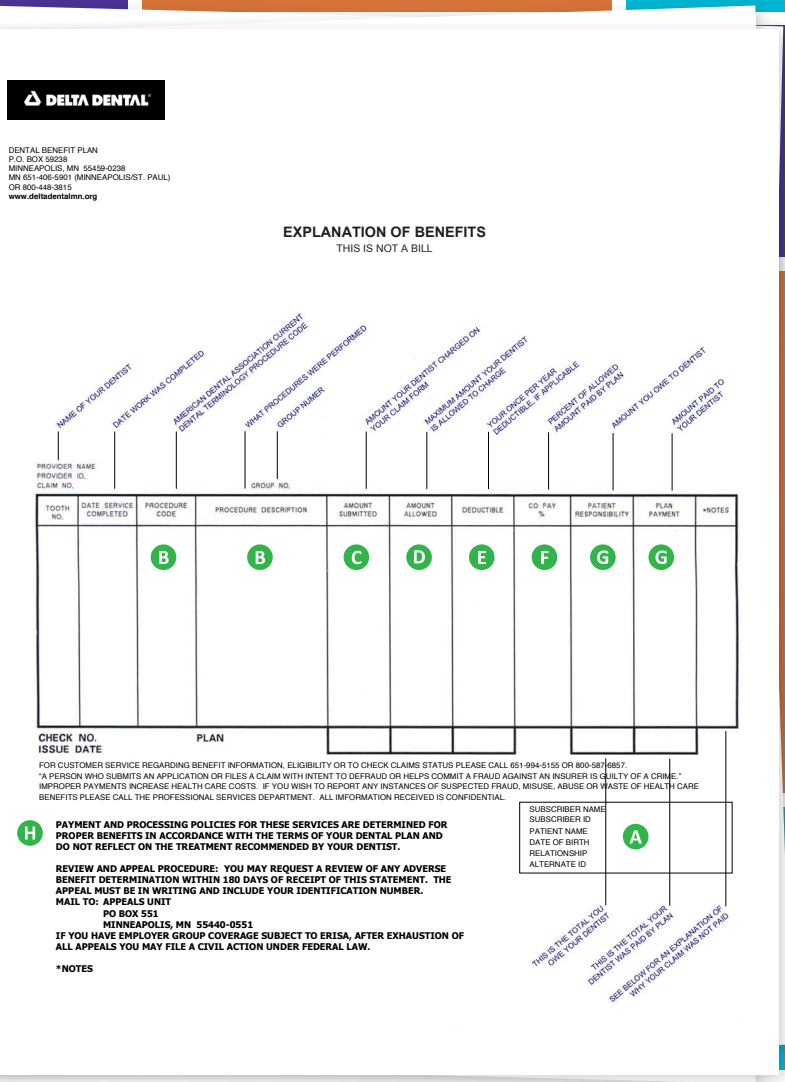
Amount Submitted is the amount the dentist charged for the services.

D

The **Amount Allowed** shows Delta Dental's contracted fees for each procedure. **Amount Allowed** is the amount determined by they dental benefit plan. These amounts are often the same. If they differ, it's because of provisions in the contract your employer purchased.

E

If you have a procedure that is not completely covered by Delta Dental, the **Deductible** is the amount applied to the service. You must pay the deductible before Delta Dental picks up its share of the tab.



DELTA DENTAL

DENTAL BENEFIT PLAN
P.O. BOX 58238
MINNEAPOLIS, MN 55459-0238
MN 651-406-5901 (MINNEAPOLIS/ST. PAUL)
OR 800-448-3815
www.deltadentalmn.org

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

NAME OF YOUR DENTIST
DATE WORK WAS COMPLETED
AMERICAN DENTAL ASSOCIATION CURRENT DENTAL TERMINOLOGY PROCEDURE CODE
WHAT PROCEDURES WERE PERFORMED
GROUP NUMER
AMOUNT YOUR DENTIST CHARGED ON YOUR CLAIM FORM
MAXIMUM AMOUNT YOUR DENTIST IS ALLOWED TO CHARGE
YOUR ONCE PER YEAR DEDUCTIBLE, IF APPLICABLE
PERCENT OF ALLOWED AMOUNT PAID BY PLAN
AMOUNT YOU OWE TO DENTIST
AMOUNT PAID TO YOUR DENTIST

PROVIDER NAME
PROVIDER ID.
CLAIM NO.
GROUP NO.

TOOTH NO.	DATE SERVICE COMPLETED	PROCEDURE CODE	PROCEDURE DESCRIPTION	AMOUNT SUBMITTED	AMOUNT ALLOWED	DEDUCTIBLE	CO PAY %	PATIENT RESPONSIBILITY	PLAN PAYMENT	*NOTES
		B	B	C	D	E	F	G	G	

CHECK NO.
ISSUE DATE
PLAN

FOR CUSTOMER SERVICE REGARDING BENEFIT INFORMATION, ELIGIBILITY OR TO CHECK CLAIMS STATUS PLEASE CALL 651-994-5155 OR 800-5876857.
"A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME."
IMPROPER PAYMENTS INCREASE HEALTH CARE COSTS. IF YOU WISH TO REPORT ANY INSTANCES OF SUSPECTED FRAUD, MISUSE, ABUSE OR WASTE OF HEALTH CARE BENEFITS PLEASE CALL THE PROFESSIONAL SERVICES DEPARTMENT. ALL IMFORMATION RECEIVED IS CONFIDENTIAL.

H

PAYMENT AND PROCESSING POLICIES FOR THESE SERVICES ARE DETERMINED FOR PROPER BENEFITS IN ACCORDANCE WITH THE TERMS OF YOUR DENTAL PLAN AND DO NOT REFLECT ON THE TREATMENT RECOMMENDED BY YOUR DENTIST.

REVIEW AND APPEAL PROCEDURE: YOU MAY REQUEST A REVIEW OF ANY ADVERSE BENEFIT DETERMINATION WITHIN 180 DAYS OF RECEIPT OF THIS STATEMENT. THE APPEAL MUST BE IN WRITING AND INCLUDE YOUR IDENTIFICATION NUMBER.
MAIL TO: APPEALS UNIT
PO BOX 551
MINNEAPOLIS, MN 55440-0551
IF YOU HAVE EMPLOYER GROUP COVERAGE SUBJECT TO ERISA, AFTER EXHAUSTION OF ALL APPEALS YOU MAY FILE A CIVIL ACTION UNDER FEDERAL LAW.

***NOTES**

SUBSCRIBER NAME
SUBSCRIBER ID
PATIENT NAME
DATE OF BIRTH
RELATIONSHIP
ALTERNATE ID

A

THIS IS THE TOTAL YOU OWE YOUR DENTIST
THIS IS THE TOTAL YOUR DENTIST WAS PAID BY PLAN
SEE BELOW FOR AN EXPLANATION OF WHY YOUR CLAIM WAS NOT PAID

F

Delta Dental Co-pay identifies the percent the plan will cover per procedure.

%

G

Patient Responsibility is the amount the patient owes the dentist. Your dentist should not bill you more than this amount. **Plan Payment** is the amount Delta Dental paid your dentist for services rendered.

H

This section includes details about the appeal process.

*Some EOBs will have additional messages to help patients understand why a procedure wasn't paid.

Delta Dental of Minnesota
DeltaDentalMN.org