DELTA DENTAL®

Understanding Your Explanation of Benefits (EOB)

After a trip to the dentist's office, you may receive an EOB from Delta Dental 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 to 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. **Amount Allowed** shows Delta Dental's contracted fees for each procedure.

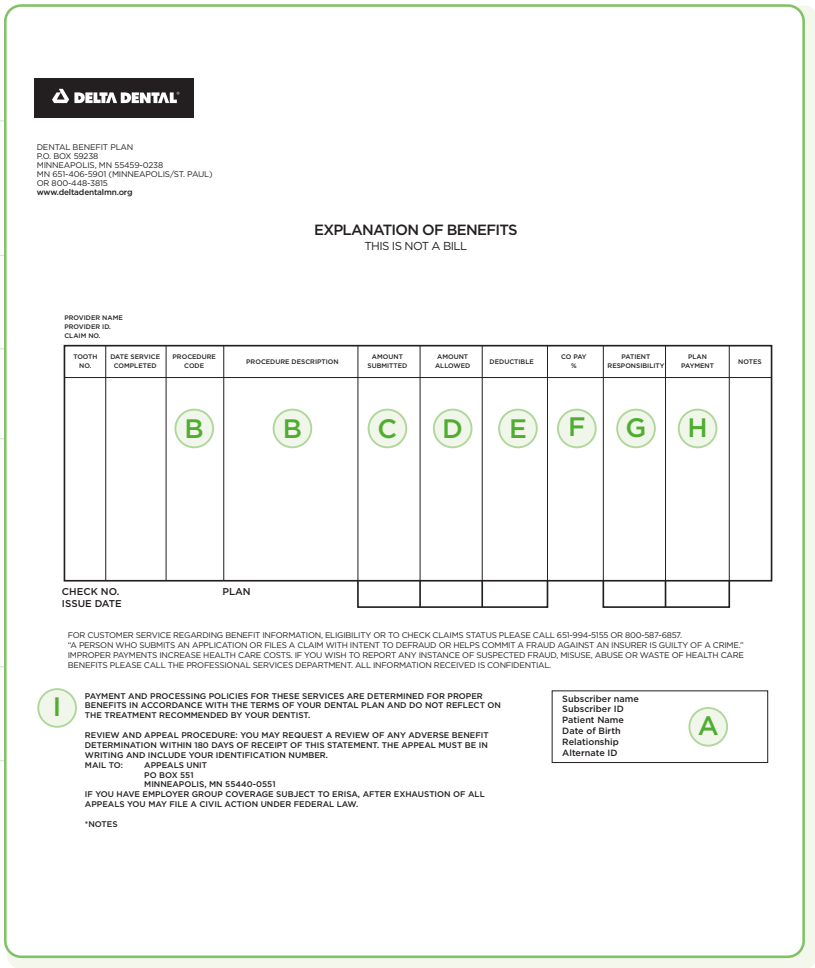
E. If you have a procedure that is not completely covered by Delta Dental, the **Deductible** is the amount applied to the service. You must pay the deductible before Delta Dental picks up its share of the tab.

F. **Co-pay** identifies the percentage 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.

H. **Plan Payment** is the amount Delta Dental paid your dentist for services rendered.

I. This section includes details about the appeals process.



DELTA DENTAL

DENTAL BENEFIT PLAN
P.O. BOX 59238
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

PROVIDER NAME
PROVIDER ID.
CLAIM 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	H	

CHECK NO.
ISSUE DATE

PLAN

FOR CUSTOMER SERVICE REGARDING BENEFIT INFORMATION, ELIGIBILITY OR TO CHECK CLAIMS STATUS PLEASE CALL 651-994-5155 OR 800-587-6857.
"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 INSTANCE OF SUSPECTED FRAUD, MISUSE, ABUSE OR WASTE OF HEALTH CARE BENEFITS PLEASE CALL THE PROFESSIONAL SERVICES DEPARTMENT. ALL INFORMATION RECEIVED IS CONFIDENTIAL.

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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

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

The Power of Smile™

Learn more about how your oral health connects to your overall health at:
DeltaDentalMN.org

DELTA DENTAL®

Delta Dental of Minnesota

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