DELTA DENTAL

Explanation of Benefits

(THIS IS NOT A BILL)

www.deltadentalnm.com

Patient Name:	**JANET DOE**
Date of Birth:	**04/19/1957**
Relationship:	**SPOUSE**
Subscriber:	**JEFFREY DOE**
Patient Acct:	**XXXXXXXX**

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Business/Dentist:	**FRITZ FLOSSMOOR, DDS**
License No.:	**XXXXX / NM (NPI: XXXXXXXXXX)**
Check No.:	**XXXXXXXX**
Issue Date:	**07/06/2010**
Receipt Date:	**07/05/2010**
Claim No.:	**XXXXXXXXXXXX**

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Pay To: C = Custodial Parent
S = Subscriber
P = Provider

Area/Tooth Code/Surface	Date of Service	Procedure Description	Submitted Amount	Maximum Approved Fee	Par Dentist Savings	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
CLIENT/ID: XXXX ABC COMPANY SUBCLIENT: XXXX ABC COMPANY		PLAN: DELTA DENTAL PLAN OF NEW MEXICO PRODUCT: DELTA DENTAL PPO									
OTHER CARRIER: DELTA DENTAL PLAN OF NEW MEXICO		OTHER CARRIER PAYMENT AMOUNT: 107.00									
	07/05/10	ORAL EXAM	37.00	37.00	0.00	37.00		100%	0.00	0.00	P
	07/05/10	CLEANING	72.00	70.00	2.00	70.00		100%	0.00	0.00	P
		Total	109.00	107.00	2.00	107.00	0.00		0.00	0.00	

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4 5 6 7 8 9 10 11 12 13 14 15

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FOR INQUIRIES: 1-877-395-9420

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CLAIMS PROCESSED BY:
DELTA DENTAL
2500 LOUISIANA BLVD NE
SUITE 600
ALBUQUERQUE, NM 87110

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Payment for these services is determined in accordance with the specific terms of your dental plan and/or Delta Dental's agreements with its participating dentists. For inquiries regarding participating dentists, please call the number listed. Delta Dental's payment decisions do not qualify as dental or medical advice. You must make all decisions about the desirability or necessity of dental procedures and services with your dentist.

If your claim was denied in whole or in part so that you must pay some amount of the claim, upon a written request and free of charge, we will provide you with a copy of any internal rule, guideline or protocol or, if applicable, an explanation of the scientific or clinical judgment relied upon in deciding your claim. If you still believe your claim should have been paid in full, you may ask to have the claim reviewed. Your written request for a formal review must be sent within 180 days of your receipt of this EOB to the address listed. You may submit any additional materials you believe support your claim. A decision will be made no later than 60 days from the date we receive your request. If your claim is denied in whole or in part after the review, you have the right to seek to have your claim paid by filing a civil action in court within one year from the final denial.

Your privacy is important to us. To access our HIPAA Notice of Privacy Practices or our Gramm-Leach-Bliley Privacy Notice, log onto our Web site and select the "HIPAA" or "GLB Privacy" link from the home page, or call our Customer Service department to request a written copy.

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ANTI-FRAUD TOLL-FREE HOTLINE 1-800-524-0147
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, you can help us lower these costs by calling our toll-free hotline. You do not need to identify yourself. Only ANTI-FRAUD calls can be accepted on this line.

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JEFFREY DOE
123 ANYWHERE STREET
ANYCITY, NM 87123

Patient Copy

EOB_Subscriber

How to read Explanation of Benefits (EOB) statements

An EOB, or Explanation of Benefits, is provided for each claim to explain how the benefits were administered on that claim. The numbers below correspond to the numbers on the following sample EOB, and are designed to help interpret your statement:

1 **Patient information, including the patient's name and date of birth, the patient's relationship to the subscriber, and the subscriber's name.**

2 **Provider information, including the business or provider name, license number and state, National Provider Identifier (NPI), check number, payment issue and receipt date, and claim number. The claim number in particular helps us answer any questions about the claim..**

3 **Client information, including the client and subclient numbers and names, the plan name, and the product name.**

For each claim line:

4 **Code identifying the part of the body, if applicable (such as eye, tooth, or tooth surface).**

5 **The date of service.**

6 **A brief description of the service.**

7 **The amount submitted by the provider.**

8 **The maximum amount we have approved for this service.**

9 **The difference between the amount the provider submitted and our maximum amount approved, indicating the savings due to the provider's participation in one of our networks.**

10 **The amount allowed under your plan.**

11 **The amount of any deductible (D), patient copay (P) or office visit fee (OV).**

12 **The percent we paid on the line.**

13 **The amount we paid.**

14 **The amount the patient is due to pay.**

15 **Whether payment is made to the provider (P), subscriber (S), or custodial parent (C).**

16 **Totals for each column.**

17 **The phone number for inquiries.**

18 **The address for inquiries.**

19 **Our standard appeal, privacy and anti-fraud language.**

20 **The name and address for mailing.**

You can help us help the environment!

Encouraging your members to go paperless can make a big impact on the environment. Did you know a single ream of paper (500 sheets) uses 6% of a tree? With your help, our electronic EOB program will reduce those numbers dramatically. Encourage your members to log on to Consumer Toolkit today to sign up for paperless EOB delivery.