DELTA DENTAL

EXPLANATION
OF
BENEFITS

P.O. Box 5402
Lisle, IL 60532
(800) 323-1743

SHERRI FRAZER
27382 PENDLETON TRACE DRIVE
SPRING TX 773860000

Patient: SHERRI FRAZER
Group No. 20410-000-00119-00001
Claim No. 2-3306-384-72
Check No 7688968
Payment Date: 10/19/2022
DDS License No: 37833 TX 001

TTH#	Date of Service	Proc. Code	Description	Submitted Amount	Approved Amount	Allowed Amount	% Co-Pay	* **	COB	Patient Pay	Delta Dental Payment	Ref code
-	10/11/22	00120	EXAM	$56.00	$56.00	$56.00	100	-	$.00		$56.00	-
-	10/11/22	00220	1ST PA XRAY	$33.00	$33.00	$33.00	100	-	$.00		$33.00	-
-	10/11/22	00230	ADDL XRAY	$29.00	$29.00	$29.00	100	-	$.00		$29.00	-
-	10/11/22	00274	BITEWINGS-4	$73.00	$73.00	$73.00	100	-	$.00		$73.00	-
-	10/11/22	04910	PERIO MAINT	$151.00	$151.00	$151.00	90	-	$.00	$15.10	$135.90	-
										$15.10	$326.90	
THIS IS NOT A BILL										Total	Total	

Check No: 7688968 Payment Date: 10/19/2022
Payee Name: SHERRI FRAZER
Address: 27382 PENDLETON TRACE DRIVE
SPRING TX 773860000

Voucher Explanation

Submitted Amount: The amount billed/charged for the procedure.

Approved Amount: The amount approved for total patient/Delta Dental payment.

Allowed Amount: The allowed fee for the covered procedure used to calculate Delta Dental's payment.

* = Exceeds Maximum: Indicates the service exceeds patient/group benefit year maximum.

** = Deductible: Indicates patient/group must meet deductible for all or a portion of the service.