Office Code: 396

Total Amount of all Checks: 2302.94

Pages: 21

Date: 1/13/2020

(1)

Fax# 877-391-0586

Check #	Amount	Check #	Amount
1. EFT	410.02	16.	
2. 3005292869	174.00	17.	
3. 12904	824.50	18.	
4. 0102617879	71.88	19.	
5. 1249925	101.00	20.	
6. 1249810	127.00	21.	
7. 10788596	76.54	22.	
8. 0034757824	174.00	23.	
9. 1050823	324.00	24.	
10.		25.	
11.		26.	
12.		27.	
13.		28.	
14.		29.	
15.		30.	

REPORT ID: FI04W400-0
PROGRAM ID: FI04L400
031266
BILLING PROVIDER: 923469 01

INVOICE DATE: 12/28/2019
PAYMENT DATE: 01/02/2020

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
REMITTANCE ADVICE - REMIT TO ADDRESS

RUN: 01/03/2020

FOUR CORNERS DENTAL LLC
STE 113
3751 N BUTLER AVE
FARMINGTON, NM
87401

** PLEASE CALL CLAIMS CUSTOMER SERVICE FOR QUESTIONS OR CLARIFICATION ABOUT THE CONTENTS OF THIS PACKAGE **
** CLAIMS CUSTOMER SERVICE MAY BE REACHED AT (602) 417-7670 OR 1-800-794-6862 (IN-STATE) OR 1-800-523-0231 (OUT-OF-STATE) **
** CLAIM STATUS & ELIGIBILITY CAN BE CHECKED ON THE AHCCCS WEB SITE BY GOING TO **
** WWW.AHCCCS.STATE.AZ.US AND CLICKING ON PLANS AND PROVIDERS **

PLEASE RETAIN THIS COPY FOR YOUR RECORDS SINCE ONLY ONE COPY OF THE REMITTANCE ADVICE WILL BE SENT.

IF ADDITIONAL COPIES ARE REQUESTED, THERE WILL BE A $4.00 CHARGE PER PAGE.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
REMITTANCE ADVICE - FINANCIAL SUMMARY
INVOICE DATE: 12/28/2019

BILLING PROVIDER: 923469 01 FOUR CORNERS DENTAL LLC NPI: 1255753976

TAX ID: 463974734
PAYMENT DATE: 01/02/2020

PAY FOR CATEGORY	CHECK NUMBER	INVOICE DATE	INVOICE NUMBER	TYPE	GROSS AMOUNT	DISCOUNT	NET AMOUNT
FEE-FOR-SERVICE	202001021128560	12/28/2019	A1936292346901		410.02	.00	410.02
TOTALS					410.02	.00	410.02

BILLING PROVIDER: 923469 01 FOUR CORNERS DENTAL LLC NPI: 1255753976
SERVICE PROVIDER: 068297 LAYTON CECIL CRAIG NPI: 179077706

INVOICE NUMBER: A1936292346901
CHECK NUMBER: 202001021128560
PAYMENT DATE: 01/02/2020

TAX ID: 463974734
FORM TYPE: DENTAL

AHCCCS ID / RECIPIENT	NAME / PATIENT ACCOUNT NUMBER	CRN / SCORE DATE	SERVICE CD/ MODIFIER	DATES OF SERVICE	BILLED AMOUNT / BILLED UNITS	ALLOWED UNITS		
A32831244	BIGTHUMB, LAKEEDA	193574000010001	D0140	12/20/2019	77.00	1.00	34.44	ALLOWED AMOUNT (*)
A32831244	34695	12/23/2019			1.00		34.44	NET PAID AMOUNT
PRICE EXPL: *AHA								
A32831244	BIGTHUMB, LAKEEDA	193574000010002	D1110	12/20/2019	98.00	1.00	47.56	ALLOWED AMOUNT (*)
A32831244	34695	12/23/2019			1.00		47.56	NET PAID AMOUNT
PRICE EXPL: *AHA								
A32831244	BIGTHUMB, LAKEEDA	193574000010003	D1208	12/20/2019	39.00	1.00	18.31	ALLOWED AMOUNT (*)
A32831244	34695	12/23/2019			1.00		18.31	NET PAID AMOUNT
PRICE EXPL: *AHA								
A70074755	GEORGE, SHAUNDIIN A	193604000001001	D0150	12/23/2019	86.00	1.00	40.49	ALLOWED AMOUNT (*)
A70074755	34736	12/26/2019			1.00		40.49	NET PAID AMOUNT
PRICE EXPL: *AHA								
A70074755	GEORGE, SHAUNDIIN A	193604000001002	D0220	12/23/2019	26.00	1.00	13.02	ALLOWED AMOUNT (*)
A70074755	34736	12/26/2019			1.00		13.02	NET PAID AMOUNT
PRICE EXPL: *AHA								
A70074755	GEORGE, SHAUNDIIN A	193604000001003	D0230	12/23/2019	23.00	1.00	10.70	ALLOWED AMOUNT (*)
A70074755	34736	12/26/2019			1.00		10.70	NET PAID AMOUNT
PRICE EXPL: *AHA								
A70074755	GEORGE, SHAUNDIIN A	193604000001004	D0230	12/23/2019	23.00	1.00	10.70	ALLOWED AMOUNT (*)
A70074755	34736	12/26/2019			1.00		10.70	NET PAID AMOUNT
PRICE EXPL: *AHA								
A70074755	GEORGE, SHAUNDIIN A	193604000001005	D0274	12/23/2019	68.00	1.00	29.99	ALLOWED AMOUNT (*)
A70074755	34736	12/26/2019			1.00		29.99	NET PAID AMOUNT
PRICE EXPL: *AHA								
A70074755	GEORGE, SHAUNDIIN A	193604000001006	D1120	12/23/2019	72.00	1.00	38.88	ALLOWED AMOUNT (*)
A70074755	34736	12/26/2019			1.00		38.88	NET PAID AMOUNT
PRICE EXPL: *AHA								
A70074755	GEORGE, SHAUNDIIN A	193604000001007	D1208	12/23/2019	39.00	1.00	18.31	ALLOWED AMOUNT (*)
A70074755	34736	12/26/2019			1.00		18.31	NET PAID AMOUNT
PRICE EXPL: *AHA								

BILLING PROVIDER: 923469 01 FOUR CORNERS DENTAL LLC NPI: 1255753976
TAX ID: 463974734

NOTE	TYPE	DESCRIPTION
		** PLEASE CALL CLAIMS CUSTOMER SERVICE FOR FURTHER EXPLANATION OR ANY DESCRIPTION **
		** CLAIMS CUSTOMER SERVICE MAY BE REACHED AT (602) 417-7670 OR 1-800-794-6862 (IN-STATE) OR 1-800-523-0231 (OUT-OF-STATE) **
		** NOTE TYPES: M = PRICING METHOD, P = PRICING TYPE, R=REASON CODE, T = TIER, X = MODIFIER
AHA	P	AHCCCS ALLOWED

9

BILLING PROVIDER: 923469 01 FOUR CORNERS DENTAL LLC NPI: 1255753976
TAX ID: 463974734

GRIEVANCE PROCEDURE

PROVIDERS SHOULD EXHAUST ALL AUTHORIZED PROCESSING PROCEDURES BEFORE FILING A GRIEVANCE.
FOR ASSISTANCE WITH PROCESSING CONTACT AHCCCS CLAIMS CUSTOMER SERVICE AT (602) 417-7670 OR 1-800-794-6862 (IN-STATE) OR 1-800-523-0231 (OUT-OF-STATE).
IF A CLAIM IS STILL IN DISPUTE, A GRIEVANCE MAY BE FILED.

PROVIDERS MUST FILE ANY GRIEVANCE CHALLENGING A CLAIM DENIAL OR ADJUDICATION WITHIN 12 MONTHS OF THE END DATE OF SERVICE, OR DATE OF DISCHARGE.
THE DATE OF RECEIPT BY THE AHCCCS OFFICE OF LEGAL ASSISTANCE IS CONSIDERED THE DATE THE GRIEVANCE IS FILED.

THE GRIEVANCE MUST BE SUBMITTED IN WRITING TO:

AHCCCS OFFICE OF LEGAL ASSISTANCE
PO BOX 25520, MD6200
PHOENIX, AZ 85002

OR HAND DELIVERED TO:

AHCCCS OFFICE OF LEGAL ASSISTANCE
701 E. JEFFERSON ST., SUITE 200
PHOENIX, AZ 85034

SEE CHAPTER 28 OF THE AHCCCS FEE FOR SERVICE PROVIDER MANUAL FOR MORE INFORMATION.

DELTA DENTAL

CHECK DISBURSEMENT

Delta Dental of Colorado

Date: 12/27/2019

DR DAVID J HERMANS FOUR CORNER 10 CHECK NO: 3005292869 AMOUNT: $174.00

Subscriber Name	Subscriber ID	Provider ID/LOC	Patient Name	Birthdate	Claim NO
BAHE TRAVIS	08000056293379	NM000000002510/1	JAYDEN	08/26/2007	2019357A555900

Code	Tooth	Date of Service	Submitted	Approved	Allowed	Deduct	Over Max	COB	DDCO Payment	Patient Pays	Prov ADJ	DDCO Coins %	Processing Policies
D0120		12/20/19	59.00	33.00	33.00	.00	.00	.00	33.00	.00	26.00	100%	
D0220	06	12/20/19	26.00	20.00	20.00	.00	.00	.00	20.00	.00	6.00	100%	
D0230	11	12/20/19	23.00	17.00	17.00	.00	.00	.00	17.00	.00	6.00	100%	
D0230	24	12/20/19	23.00	17.00	17.00	.00	.00	.00	17.00	.00	6.00	100%	
D0274		12/20/19	68.00	40.00	40.00	.00	.00	.00	40.00	.00	28.00	100%	
D1120		12/20/19	72.00	47.00	47.00	.00	.00	.00	47.00	.00	25.00	100%	
D1208		12/20/19	39.00	25.00	.00	.00	.00	.00	.00	25.00	14.00	100%	10
		TOTAL:	**310.00**	**199.00**	**174.00**	**.00**	**.00**	**.00**	**174.00**	**25.00**	**111.00**	**DED MET**	**.00**

SALAZAR JENNIFER	XXXXX2216	NM000000002510/1	ORLANDO	02/26/2004	20193532037800

Code	Tooth	Date of Service	Submitted	Approved	Allowed	Deduct	Over Max	COB	DDCO Payment	Patient Pays	Prov ADJ	DDCO Coins %	Processing Policies
D2740	07	10/21/19	1,045.00	.00	.00	.00	.00	.00	.00	.00	1,045.00	50%	968
		TOTAL:	**1,045.00**	**.00**	**.00**	**.00**	**.00**	**.00**	**.00**	**.00**	**1,045.00**	**DED MET**	**.00**

PROCESSING POLICY EXPLANATION:

10 - This procedure is a benefit once in a calendar year. Refer to the Benefits/Coverage section of the employee booklet.

968 - This service was previously paid/predetermined or it is on a claim form currently being processed by Delta Dental.

Payments are made to the billing entity, but listing the treating dentist in the correct field is mandatory on all of your claims.

8

Payment for these services is determined in accordance with the specific terms of the patient's dental plan. Claims requiring professional judgement for benefit determination have been reviewed by a dental consultant.

THIS DOCUMENT CONTAINS SECURITY FEATURES - SEE BACK FOR DETAILS

DELTA DENTAL

Delta Dental of Colorado
PO Box 173803
Denver CO 80217-3803

CHECK NO.
3005292869

DATE
12/27/2019

Wells Fargo Bank West, NA
Grand Junction, CO
82-91
1021

VOID AFTER 90 DAYS
AMOUNT
$174.00

PAY ** ONE HUNDRED SEVENTY-FOUR AND 00/100 DOLLARS **

TO THE ORDER OF

>000653 01256 002 P51183

DR DAVID J HERMANS FOUR CORNER
3751 N Butler Ave Ste 113
Farmington, NM 87401-6425

Helen Doyle

⑈3005292869⑈ ⑆102100918⑆ 8012703189⑈

000653 01256 002 P51183 01/01

NAVAJO HOUSING AUTHORITY
POST OFFICE BOX 4980
WINDOW ROCK, AZ 86515-4980

Check No: 12904
Date: 12/10/19

SUMMARY OF BENEFITS

INS. SSN. NAME OF INSURED | PATIENT NAME | GROUP NAME

CLAIM NUMBER/ PATIENT ACCT NBR	SERVICE DATES	PROCED.	CHARGE	NOT COVERED	RSN CODE	CO-PAY	OVER FEE SCHEDULE	PROVIDER DISCOUNT	DEDUCT.	COINS %	OTHER INSURANCE	PAYMENT
527-17-4441 MARLINDA J. CHARLIE			ALYSSA A. NESKAHI								NAVAJO HOUSING AUTHORITY	
002S0721917058500 0397773800007920P	12/01/19-12/01/19	D8670	189.00	.00		.00	.00	.00	.00	50	.00	94.50
Subtotals			**189.00**	**.00**		**.00**	**.00**	**.00**	**.00**		**.00**	**94.50**
529-90-8917 MARY VANDEVER			MARY VANDEVER								NAVAJO HOUSING AUTHORITY	
002S0721913423202 0397807300007946P	09/13/19-09/13/19	D8090	1500.00	.00		.00	.00	.00	.00	50	.00	750.00
Subtotals			**1500.00**	**.00**		**.00**	**.00**	**.00**	**.00**		**.00**	**750.00**

CHECK TOTALS	CLAIMS	CHARGES	NOT COVERED	CO-PAYMENTS	OVR FEE SCHD	DISCOUNTED	DEDUCTIBLE	OTHER INSNCE	TOTAL PAID
	2	1689.00	.00	.00	.00	.00	.00	.00	844.50

9

NAVAJO HOUSING AUTHORITY
POST OFFICE BOX 4980
WINDOW ROCK, AZ 86515-4980

WELLS FARGO BANK, N.A.

CHECK NO
12904

11-241210

DATE: 12/10/19

PAY: *** EIGHT HUNDRED FORTY FOUR DOLLARS AND 50/100 ***

AMOUNT: ********844.50**

TO THE ORDER OF

FOUR CORNERS ORTHODONTIC CENTERS INC
3751 N BUTLER AVE
STE 113
FARMINGTON, NM 87401

Authorized Signature

⑈00012904⑈ ⑆121000248⑆4121855175⑈

BlueCross. BlueShield.
Federal Employee Program.
FEP BlueDental®

PO Box 75
Minneapolis, MN 55440-0075

FEP BlueDental

EXPLANATION OF BENEFITS

Fepbluedental.com
855-504-BLUE (2583)
8:00am - 8:00pm ET M-F

000000008399P*********
FOUR CORNERS ORTHODONTIC CENTERS INC
3751 N BUTLER AVE STE 113
FARMINGTON, NM 87401-6425

Payee: FOUR CORNERS ORTHODONTIC CENTE
Check #: 0102617879
Issue Date: 01/01/2020

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

Provider ID: 850448816 **Provider:** DAVID HERMAN **Treating Addr:** 3751 N BUTLER AVE STE 113 IN NETWORK
Member ID: F75266283 **Member:** MIRANDA MONTOYA **Group-Subgrp:** FEPBD1-0002
Claim: 43740261 **Patient:** MIRANDA MONTOYA **Patient DOB:** 02/18/1976 (Self)

Tooth # - Surface	Service Date	Proc Code	Procedure Description	Submitted Amount	Approved Amount	Allowed Amount	Network Savings	Deductible Amt	Cov %	Patient Owes	Plan Payment	Notes *
	12/15/2019	D8889	Scheduled Ortho Payment	71.88	71.88	71.88	0.00	0.00	0	0.00	71.88	
								Current Plan Payment:			$71.88	

Reconsideration Comments:

10

BlueCross. BlueShield.
Federal Employee Program.
FEP BlueDental

Check No.: 0102617879
WELLS FARGO
VAN WERT OH
Acct. No.: 9649481414
Issue Date: 01/01/2020

56-382
412

PO Box 75
Minneapolis, MN 55440-0075

AMOUNT
********$71.88

VOID AFTER 90 DAYS

Security features included. Details on back.

PAY SEVENTY ONE DOLLARS AND EIGHTY EIGHT CENTS

TO THE ORDER OF FOUR CORNERS ORTHODONTIC CENTERS INC

Larry L Durrance

⑈0102617879⑈ ⑆041203824⑆ 9649481414⑈

↑ DETACH HERE ↑ ↑ DETACH HERE ↑

FEP BlueDental
855-504-BLUE (2583)
Fepbluedental.com

PAYMENT SUMMARY

Provider Name: FOUR CORNERS ORTHODONTIC CENTERS INC
Provider ID: 850448816

Claim #	Member ID	Member Name	Patient Name	Submitted Amount	Payment
43740261	F75266283	MIRANDA MONTOYA	MIRANDA MONTOYA	71.88	71.88
Check #: 0102617879		**Issue Date:** 01/01/2020	**Current Plan Payment:**		$71.88

FORM: CLMFEPBD001CHK 12/19/2013 (PReS) 01/02/2020 11:33:27 CLM_PMT_FEPBD_PRESORT_CHECK_6_20200102111147.PS page 18456

BlueCross®
BlueShield®
Federal Employee Program®
P.O. Box 7344 Chicago, IL 60680-7344

BLUE CROSS AND BLUE SHIELD
OF NEW MEXICO
P. O. BOX 27630
ALBUQUERQUE, NEW MEXICO 87125
1-800-245-1609

**********ALL FOR AADC 870
18618 1 AB 0.412 35

CRAIG LAYTON
3751 N BUTLER AVE STE 113
FARMINGTON NM 87401-6425

PROCESS DATE 01/02/2020
PREVIOUS REMIT 12/31/2019
REMITTANCE REPORT NUMBER 0012

PROFESSIONAL CLAIM
PROVIDER NUMBER: 00NM008EG0
CHECK NUMBER: 1249925

PATIENT NAME: RODRIGUEZ, SANDRA J ACC #: 005923

ID #: R60977717 CLAIM NUMBER: 193507408554RB TRANS ID: 43293263110 SUB LIABILITY: 170.00

PROC CODE	FROM AND TO SERVICE DATES	PROVIDER CHARGES	NONCOVERED CHARGES	COINS COPAY	DED	COB	NEGOTIATED SAVINGS	PREV AMT PD	AMOUNT PAID	REASON CODE
D0150	11042019 11042019	86.00		30.00			30.00		26.00	
D0220	11042019 11042019	26.00	26.00						.00	219
D0230	11042019 11042019	23.00	23.00						.00	219
D0230	11042019 11042019	23.00	23.00						.00	219
D0274	11042019 11042019	68.00	68.00						.00	219
D1110	11042019 11042019	98.00					23.00		75.00	
CLAIM/TRANS ID TOTALS:		324.00	140.00	30.00			53.00		101.00	

REASON CODE EXPLANATIONS

219 BENEFITS ARE PROVIDED FOR THE DENTAL SERVICES SPECIFICALLY DESCRIBED IN YOUR BLUE CROSS AND BLUE SHIELD SERVICE BENEFIT PLAN BROCHURE. THE DENTAL CARE YOU RECEIVED IS NOT LISTED AS A COVERED SERVICE. THEREFORE, YOU ARE RESPONSIBLE FOR THESE CHARGES.

NM13230M 20200105B02 JF52
20200102 000003 Env [18,618] 1 of 2

NM13230M 20200105B02 JF52
20200102 000003 Env [18,618] 2 of 2

13

NC0006 08/19 NM02427

BlueCross BlueShield of New Mexico

A Division of Health Care Service Corporation,
a Mutual Legal Reserve Company,
an Independent Licensee of the
Blue Cross and Blue Shield Association
P.O. Box 27630
Albuquerque, NM 87125

70-2382
719

1249925

The Northern Trust Company
Chicago, IL
Payable Through
Oakbrook Terrace, IL

FEDERAL EMPLOYEES PROGRAM

I.D. NUMBER: R60977717
CLAIM NUMBER: 790-193507408554RB
BATCH NUMBER: 86129
PROVIDER NO. 00NM008EG0

MO.	DAY	YR.
01	02	20

AMOUNT

$********101 | 00

EXACTLY ********101 DOLLARS AND 00 CENTS

PAY TO THE ORDER OF

CRAIG LAYTON
3751 N BUTLER AVE STE 113
FARMINGTON , NM 874010000

PLEASE NEGOTIATE PROMPTLY. THIS CHECK IS VOID 1 YEAR AFTER DATE OF ISSUE.

Security Features Details on back.

AUTHORIZED SIGNATURE

⑈1249925⑈ ⑆071923828⑆ 30219518⑈

BlueCross®
BlueShield®
Federal Employee Program®
P.O. Box 7344 Chicago, IL 60680-7344

BLUE CROSS AND BLUE SHIELD
OF NEW MEXICO
P. O. BOX 27630
ALBUQUERQUE, NEW MEXICO 87125
1-800-245-1609

**********ALL FOR AADC 870
5311 1 AB 0.412 13
CRAIG LAYTON
3751 NORTH BUTLER AVE STE 113
FARMINGTON NM 87401-6425

PAGE 1
PROCESS DATE 12/31/2019
PREVIOUS REMIT 07/22/2019
REMITTANCE REPORT NUMBER 0011

PROFESSIONAL CLAIM
PROVIDER NUMBER: 00NM008EG0
CHECK NUMBER: 1249810

PATIENT NAME: ROMERO, ALEXA ACC #:

ID #: R60643636 CLAIM NUMBER: 193507408582RB TRANS ID: 43292654495 SUB LIABILITY: 0.00

PROC CODE	FROM AND TO SERVICE DATES	PROVIDER CHARGES	NONCOVERED CHARGES	COINS COPAY	DED	COB	NEGOTIATED SAVINGS	PREV AMT PD	AMOUNT PAID	REASON CODE
D0150	11042019 11042019	86.00		30.00			30.00		26.00	
D0220	11042019 11042019	26.00	26.00						.00	219
D0230	11042019 11042019	23.00	23.00						.00	219
D0230	11042019 11042019	23.00	23.00						.00	219
D0274	11042019 11042019	68.00	68.00						.00	219
D1110	11042019 11042019	98.00					23.00		75.00	
D1208	11042019 11042019	39.00					13.00		26.00	
CLAIM/TRANS ID TOTALS:		363.00	140.00	30.00			66.00		127.00	

REASON CODE EXPLANATIONS

219 BENEFITS ARE PROVIDED FOR THE DENTAL SERVICES SPECIFICALLY DESCRIBED IN YOUR BLUE CROSS AND BLUE SHIELD SERVICE BENEFIT PLAN BROCHURE. THE DENTAL CARE YOU RECEIVED IS NOT LISTED AS A COVERED SERVICE. THEREFORE, YOU ARE RESPONSIBLE FOR THESE CHARGES.

14

NM13230M 20200102B08 JCD5 20191231 000001 Env [5,311] 1 of 2

IL0606 SRP 1215

NM13230M 20200102B08 JCD5
20191231 000001 Env [5.311] 2 of 2

15

NC0006 08/19 NM02427

BlueCross BlueShield of New Mexico

A Division of Health Care Service Corporation,
a Mutual Legal Reserve Company,
an Independent Licensee of the
Blue Cross and Blue Shield Association
P.O. Box 27630
Albuquerque, NM 87125

70-2382
719

1249810

FEDERAL EMPLOYEES PROGRAM

The Northern Trust Company
Chicago, IL
Payable Through
Oakbrook Terrace, IL

I.D. NUMBER: R60643636
CLAIM NUMBER: 790-193507408582RB
BATCH NUMBER: 86129
PROVIDER NO. 00NM008EG0

MO.	DAY	YR.
12	31	19

AMOUNT

EXACTLY *******127 DOLLARS AND 00 CENTS

$*******127	00

PAY TO THE ORDER OF

CRAIG LAYTON
3751 NORTH BUTLER AVE
STE 113
FARMINGTON , NM 874010000

PLEASE NEGOTIATE PROMPTLY. THIS CHECK IS VOID 1 YEAR AFTER DATE OF ISSUE.

AUTHORIZED SIGNATURE

Security Features Details on back.

⑈1249810⑈ ⑆071923828⑆ 30219518⑈

DELTA DENTAL

Delta Dental of Oklahoma
PO Box 548809
Oklahoma City, OK 73154

Forwarding Service Requested

Claim Payment Statement - Dentist

**********ALL FOR AADC 870
PB-0MA-501-ENV 3033 8
FOUR CORNERS ORTHODONTIC CENTERS
3751 N BUTLER AVE STE 113
FARMINGTON NM 87401-6425

Customer Service Information

Questions? Contact Us

Phone:	405-607-2189
Toll Free:	800-990-7337
E-mail:	CustomerService@DeltaDentalOK.org
Online:	DeltaDentalOK.org

Reference Info

EFT/Check No.	6788596
Check Date:	12/31/19
Paid To:	FOUR CORNERS ORTHODONTIC CENTERS

Date of Issue: 12/31/2019

Claim No:	1934451617
Plan Type:	DELTA DENTAL PPO - PLUS PREMIER
Group No:	0005782-1071
Group:	FLINTCO, LLC

Patient:	LATRELL HALWOOD	**Provider:**	DAVID HERMAN
Patient D.O.B.:	02/26/05	**License No.:**	NM1859
Rel:	DEPENDENT	**Specialty:**	ORTHODONTIST

Date of Service	Tooth Code	Tooth Surface	Submitted Proc Code	Approved Proc Code	Submitted Amount	Approved Amount	Allowed Amount	Provider Adjust.	Patient Deductible	DDOK Co-Ins %	DDOK Pays	Patient Pays	Processing Policies
12/10/19			D8080	D8080	$153.08	$153.08	$153.08	$0.00	$0.00	50%	$76.54	$76.54	
				Claim Totals:	**$153.08**	**$153.08**	**$153.08**	**$0.00**	$0.00		$76.54	$76.54	

Delta Dental's Total Payment:	$76.54
Total Patient Responsibility to the Dentist:	$76.54

Other Carrier:	
Primary Payment Amount:	$0.00

Important Notice

Payment for these services is determined in accordance with the specific terms of the patient's dental plan and/or Delta Dental's agreement with your office. This statement is based on individual and/or employment eligibility, and Delta Dental records as of the date of processing.

For questions concerning this statement, please contact Customer Service at 405-607-2189 (OKC Metro) or 800-990-7337 (Toll Free).

To Report Possible Fraud

Insurance fraud increases the cost of health care. If you are aware of any false information submitted to Delta Dental of Oklahoma, you can help us lower these costs by notifying our anti-fraud coordinator.

Our anti-fraud coordinator can be reached at 405-607-2100 (OKC Metro) or 800-522-0188 (Toll Free). You do not need to identify yourself. Press *5 or request to speak with the anti-fraud coordinator. For additional information and/or to submit a fraud report via secure email or fax, please visit DeltaDentalOK.org/company/reportfraud/

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for proceeds of any insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Continued on back

[-CC]

Reference Info

EFT/Check No.	6788596
Check Date:	12/31/19
Paid To:	FOUR CORNERS ORTHODONTIC CENTERS

17

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND A "VOID" PANTOGRAPH WHICH BECOMES PROMINENT WHEN PHOTOCOPIED

DELTA DENTAL

Delta Dental of Oklahoma
PO Box 548809
Oklahoma City, OK 73154-8809

BANK OF OKLAHOMA N.A.
OKLAHOMA CITY, OKLAHOMA
86-3/1039

CHECK NO.: 6788596
CHECK DATE: 12/31/2019

AMOUNT
**********$76.54

Void after 180 days

PAY ******Seventy Six Dollars and Fifty Four Cents******

TO THE ORDER OF FOUR CORNERS ORTHODONTIC CENTERS

Authorized Signature

⑈6788596⑈ ⑆103900036⑆ 8140570 12⑈

UnitedHealthcare
P.O. Box 30567
Salt Lake City, UT 84130-0567

EXPLANATION OF DENTAL PLAN REIMBURSEMENT
THIS IS NOT A BILL

Sheet: Page 1 of 5
Date: 12/31/2019
Check No: 0034757824
Check Amt: $174.00

001IMBIMPLANCHECK0004001-11397-01
DR DAVID HERMANS FOUR CORNERS
3751 N BUTLER AVE STE 113
FARMINGTON NM 87401-6425

For faster service, submit your claim, including attachments, online at no charge. Get paid quicker via electronic payments and verify your provider data at UHCDental.com (post login Provider Self Service Quick Link).

DEN-PEOB1

18

UnitedHealthcare
P.O. Box 30567
Salt Lake City, UT 84130-0567

Citibank, N.A.
One Penns Way
New Castle, DE 19720

62-20/311 **0034757824**

Date
12/31/19

PAY:
**********$174.00

Void If Not Cashed Within 90 Days

Pay One Hundred Seventy Four Dollars and Zero Cents**********

TO THE ORDER OF
DR DAVID HERMANS FOUR CORNERS
3751 N BUTLER AVE STE 113
FARMINGTON NM 87401

Authorized Signature Required

Details on Back
Security Features Included

⑈0034757824⑈ ⑆031100209⑆ 38746916⑈

SUMMIT

Summit Administration Services, Inc.
P.O. Box 25160
Scottsdale AZ 85255-0102

Explanation of Benefits

AR[-]

Forwarding Service Requested

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

**********MIXED AADC 870
PB-STL_UNSORTED-MACH-ENV 6039 13
FOUR CORNERS DENTAL LLC
3751 N BUTLER AVE STE 113
FARMINGTON NM 87401-6425

Customer Service

Questions: Please call Summit
(Toll Free) 1 (888) 690-2020

Group Name: ROUGH ROCK COMM SCHOOL
Paid Date: 12/26/2019
Check Date: 12/26/2019
Check #: 650823

Claim #: 21932607400
Patient: CAROLINE JOHNSON

Provider:FOUR CORNERS DENTAL LLC
Employee:CAROLINE JOHNSON

Treatment Dates	Service Code	Procedure Code	Billed Amount	Not Covered	Reason Code	PPO Discount	Covered Amount	Deductible Amount	Co-pay Amount	Paid At	Payment Amount
12/17-12/17/2019	900	D0150	$86.00	$0.00		$0.00	$86.00	$0.00	$0.00	100%	$86.00
12/17-12/17/2019	902	D0220	$26.00	$0.00		$0.00	$26.00	$0.00	$0.00	100%	$26.00
12/17-12/17/2019	902	D0230	$23.00	$0.00		$0.00	$23.00	$0.00	$0.00	100%	$23.00
12/17-12/17/2019	902	D0230	$23.00	$0.00		$0.00	$23.00	$0.00	$0.00	100%	$23.00
12/17-12/17/2019	913	D0274	$68.00	$0.00		$0.00	$68.00	$0.00	$0.00	100%	$68.00
12/17-12/17/2019	905	D1110	$98.00	$0.00		$0.00	$98.00	$0.00	$0.00	100%	$98.00
	Column Totals		$324.00	$0.00		$0.00	$324.00	$0.00	$0.00		$324.00

Coinsurance Total: $0.00

Other Insurance Credits $0.00

Patient's Responsibility: $0.00

Adjusted Payment $324.00

Service Code/Description

900	EXAMS/INITIAL/PERIODIC
902	X-RAYS
913	BITEWING XRAYS
905	PROPHYS

21

Payment Details

Paid To	Check No.	Amount
FOUR CORNERS DENTAL LLC	650823	$324.00

SUMMIT

2-28
710

CHECK NO.650823

ISSUE DATE 12/26/2019

AMOUNT
**********$324.00

PAY TO THE ORDER OF

****** THREE HUNDRED TWENTY FOUR DOLLARS AND NO/100 ******

FOUR CORNERS DENTAL LLC

BMO HARRIS BANK.
CHICAGO IL

Void after 180 days

Authorized Signature

⑈650823⑈ ⑆071000288⑆ 40105 18⑈