Beam Insurance Administrators
PO Box 75372
Cincinnati, OH 45275

UT BCDO SPECIALTY DENTAL SERVICES, PLLC
BURG CHILDRENS DENTISTRY & ORT
3401 N CENTER ST STE 250
LEHI UT 84043

Customer Service: 800-648-1179

Your name, UT BCDO SPECIALTY DENTAL SERVICES, PLLC, and Tax ID have been verified by the IRS.

THIS IS NOT A BILL

Tax ID: *854364176* ***EPC Draft #:*** *296422750* ***Payment Week:*** *22* ***Payment Date:*** *06/01/2023*

Claim Number: 2023-05-16-14371-03 **Patient Account No.:** 9531872594
Patient Name: Wilcox, Willow **Rendering Provider:** David J Hadley
Planholder: Wilcox, Michael **Planholder Relationship:** Dependent

Line No.	ADA Codes/Descriptions	Tooth No.	Date of Service	Submitted Charge	Discounts and Adjustments	Allowed Charge	Copay	Co-Ins	Deductible	Ineligible	Patient Total	Benefit	Remark Codes
1	D0120/		05/16/23	39.00	9.00	30.00	0.00	0.00	0.00	0.00	0.00	30.00	45
2	D0220/	8	05/16/23	22.00	6.00	16.00	0.00	0.00	0.00	0.00	0.00	16.00	45
3	D0230/	24	05/16/23	19.00	6.00	13.00	0.00	0.00	0.00	0.00	0.00	13.00	45
4	D0272/		05/16/23	36.00	10.00	26.00	0.00	0.00	0.00	0.00	0.00	26.00	45
5	D1120/		05/16/23	52.00	11.00	41.00	0.00	0.00	0.00	0.00	0.00	41.00	45
6	D1206/		05/16/23	36.00	11.00	25.00	0.00	0.00	0.00	0.00	0.00	25.00	45
			TOTALS	204.00	53.00	151.00	0.00	0.00	0.00	0.00	0.00	151.00	

Claim Number: 2023-05-16-14371-04 **Patient Account No.:** 9531872594
Patient Name: Wilcox, Wells **Rendering Provider:** David J Hadley
Planholder: Wilcox, Michael **Planholder Relationship:** Dependent

Line No.	ADA Codes/Descriptions	Tooth No.	Date of Service	Submitted Charge	Discounts and Adjustments	Allowed Charge	Copay	Co-Ins	Deductible	Ineligible	Patient Total	Benefit	Remark Codes
1	D0120/		05/16/23	39.00	9.00	30.00	0.00	0.00	0.00	0.00	0.00	30.00	45
2	D0220/	8	05/16/23	22.00	6.00	16.00	0.00	0.00	0.00	0.00	0.00	16.00	45
3	D0230/	24	05/16/23	19.00	6.00	13.00	0.00	0.00	0.00	0.00	0.00	13.00	45
4	D0272/		05/16/23	36.00	10.00	26.00	0.00	0.00	0.00	0.00	0.00	26.00	45
5	D1120/		05/16/23	52.00	11.00	41.00	0.00	0.00	0.00	0.00	0.00	41.00	45
			TOTALS	168.00	42.00	126.00	0.00	0.00	0.00	0.00	0.00	126.00	

Claim Number: 2023-05-24-00504-09 **Patient Account No.:** 5452768043
Patient Name: Peterson, Emmett I **Rendering Provider:** David J Hadley
Planholder: Peterson, Grant R **Planholder Relationship:** Dependent

Line No.	ADA Codes/Descriptions	Tooth No.	Date of Service	Submitted Charge	Discounts and Adjustments	Allowed Charge	Copay	Co-Ins	Deductible	Ineligible	Patient Total	Benefit	Remark Codes
1	D0120/		05/24/23	39.00	9.00	30.00	0.00	0.00	0.00	0.00	0.00	30.00	45
2	D0220/	8	05/24/23	22.00	6.00	16.00	0.00	0.00	0.00	0.00	0.00	16.00	45
3	D0230/	24	05/24/23	19.00	6.00	13.00	0.00	0.00	0.00	0.00	0.00	13.00	45
4	D0272/		05/24/23	36.00	10.00	26.00	0.00	0.00	0.00	0.00	0.00	26.00	45
5	D1120/		05/24/23	52.00	11.00	41.00	0.00	0.00	0.00	0.00	0.00	41.00	45
6	D2392/	J	05/24/23	146.00	17.00	129.00	0.00	15.80	50.00	0.00	65.80	63.20	1 2 45
7	D9230/		05/24/23	30.00	0.00	0.00	0.00	30.00	0.00	0.00	30.00	0.00	2
			TOTALS	344.00	59.00	255.00	0.00	45.80	50.00	0.00	95.80	189.20	

Claim Number: 2023-05-24-00504-10 **Patient Account No.:** 5452768043
Patient Name: Peterson, Ethan A **Rendering Provider:** David J Hadley
Planholder: Peterson, Grant R **Planholder Relationship:** Dependent

Line No.	ADA Codes/Descriptions	Tooth No.	Date of Service	Submitted Charge	Discounts and Adjustments	Allowed Charge	Copay	Co-Ins	Deductible	Ineligible	Patient Total	Benefit	Remark Codes
1	D0120/		05/24/23	39.00	9.00	30.00	0.00	0.00	0.00	0.00	0.00	30.00	45
2	D0220/	8	05/24/23	22.00	6.00	16.00	0.00	0.00	0.00	0.00	0.00	16.00	45
3	D0230/	24	05/24/23	19.00	6.00	13.00	0.00	0.00	0.00	0.00	0.00	13.00	45
4	D0272/		05/24/23	36.00	10.00	26.00	0.00	0.00	0.00	0.00	0.00	26.00	45
5	D1120/		05/24/23	52.00	11.00	41.00	0.00	0.00	0.00	0.00	0.00	41.00	45
6	D1351/	3	05/24/23	37.00	7.00	30.00	0.00	0.00	0.00	0.00	0.00	30.00	45
7	D1351/	14	05/24/23	37.00	7.00	30.00	0.00	0.00	0.00	0.00	0.00	30.00	45
8	D1351/	19	05/24/23	37.00	7.00	30.00	0.00	0.00	0.00	0.00	0.00	30.00	45
9	D1351/	30	05/24/23	37.00	7.00	30.00	0.00	0.00	0.00	0.00	0.00	30.00	45
10	D2392/	B	05/24/23	146.00	17.00	129.00	0.00	15.80	50.00	0.00	65.80	63.20	1 2 45
	TOTALS			462.00	87.00	375.00	0.00	15.80	50.00	0.00	65.80	309.20	

Claim Number: 2023-05-24-00504-11 **Patient Account No.:** 5452768043
Patient Name: Peterson, Ace R **Rendering Provider:** David J Hadley
Planholder: Peterson, Grant R **Planholder Relationship:** Dependent

Line No.	ADA Codes/Descriptions	Tooth No.	Date of Service	Submitted Charge	Discounts and Adjustments	Allowed Charge	Copay	Co-Ins	Deductible	Ineligible	Patient Total	Benefit	Remark Codes
1	D0120/		05/24/23	39.00	9.00	30.00	0.00	0.00	0.00	0.00	0.00	30.00	45
2	D0220/	8	05/24/23	22.00	6.00	16.00	0.00	0.00	0.00	0.00	0.00	16.00	45
3	D0230/	24	05/24/23	19.00	6.00	13.00	0.00	0.00	0.00	0.00	0.00	13.00	45
4	D0272/		05/24/23	36.00	10.00	26.00	0.00	0.00	0.00	0.00	0.00	26.00	45
5	D1120/		05/24/23	52.00	11.00	41.00	0.00	0.00	0.00	0.00	0.00	41.00	45
	TOTALS			168.00	42.00	126.00	0.00	0.00	0.00	0.00	0.00	126.00	

Claim Number: 2023-05-24-00504-12 **Patient Account No.:** 5452768043
Patient Name: Peterson, Aria R **Rendering Provider:** David J Hadley
Planholder: Peterson, Grant R **Planholder Relationship:** Dependent

Line No.	ADA Codes/Descriptions	Tooth No.	Date of Service	Submitted Charge	Discounts and Adjustments	Allowed Charge	Copay	Co-Ins	Deductible	Ineligible	Patient Total	Benefit	Remark Codes
1	D0120/		05/24/23	39.00	9.00	30.00	0.00	0.00	0.00	0.00	0.00	30.00	45
2	D0220/	8	05/24/23	22.00	6.00	16.00	0.00	0.00	0.00	0.00	0.00	16.00	45
3	D0230/	24	05/24/23	19.00	6.00	13.00	0.00	0.00	0.00	0.00	0.00	13.00	45
4	D1120/		05/24/23	52.00	11.00	41.00	0.00	0.00	0.00	0.00	0.00	41.00	45
	TOTALS			132.00	32.00	100.00	0.00	0.00	0.00	0.00	0.00	100.00	

Claim Number: 2023-05-25-00504-02 **Patient Account No.:** 5452768043
Patient Name: Peterson, Ethan A **Rendering Provider:** David J Hadley
Planholder: Peterson, Grant R **Planholder Relationship:** Dependent

Line No.	ADA Codes/Descriptions	Tooth No.	Date of Service	Submitted Charge	Discounts and Adjustments	Allowed Charge	Copay	Co-Ins	Deductible	Ineligible	Patient Total	Benefit	Remark Codes
1	D9230/		05/25/23	30.00	0.00	0.00	0.00	30.00	0.00	0.00	30.00	0.00	2
	TOTALS			30.00	0.00	0.00	0.00	30.00	0.00	0.00	30.00	0.00	

Provider Explanation of Benefits Statement Summary	Submitted Charge	Paid By Other	Adjustments	Patient Responsibilit	Benefit Amount
Beam	1,508.00	0.00	315.00	191.60	1,001.40
Statement Totals	1,508.00	0.00	315.00	191.60	1,001.40

Document Total	
Net Payment Amount:	$1,001.40
Payment Adjustments:	$0.00
Total Payment:	$1,001.40

Explanations

Administered by	Code	Description
Beam	1	Deductible Amount
	2	Coinsurance Amount
	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)

Services performed by a network dentist in the DBP Network.

Important Notices:
The diagnosis and treatment codes (and their meaning) related to the service that is the subject of this Explanation of Benefits (EOB) are available upon request made to the carrier.
If you suspect fraud or abuse involving the services described in this Explanation of Benefits or would like to report other healthcare fraud related issues, please call the Toll-Free Hotline at (800) 648-1179 as required by state law. You may email us at help@beam.dental to report suspected fraud. If you are covered by more than one (1) health benefit plan, you should file all your claims with each plan. Please see additional attached notices for state specific information on appeal rights and adverse benefit determinations. This benefit reflects your agreement with Dental Benefit Providers, Inc. Insurance products underwritten by Nationwide Life Insurance Company, Columbus, OH and administered by Beam Insurance Administrators LLC.

You can find information on covered procedures and their frequency and limitations, along with information on your right to bring civil action in your Certificate of Insurance.

Carrier Contact Information
Nationwide Life Insurance Company
One Nationwide Plaza
Columbus, OH 43215-2220

Appeal Information
If your claim was denied or only partially paid and you are responsible for the unpaid amount, you have the right to appeal. To request a first level appeal, you must submit your written appeal, and any supporting documentation, within 180 days after receipt of notice of adverse determination. Members or Providers may call Beam Insurance Administrators toll free at (800) 648-1179 to request an appeal or email appeals@beam.dental. Once your appeal is received a decision will be made in 30-60 (depending on your state requirements) calendar days. If you do not agree with our appeal decision you may request a voluntary review if you have new or additional information. You may also file an appeal to the state Department of Insurance. The address can be found in your insurance certificate or by contacting support@beam.dental

Utah Insurance Department, Office of Consumer Health Assistance
Suite 3110
State Office Building
Salt Lake City UT 84114

Electronic Payment Clearinghouse

Beam Insurance Administrators
PO Box 75372
Cincinnati, OH 45275

HUNTINGTON NATIONAL BANK
Westerville OH 43081

56-1512
441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO.	296422750
DRAFT DATE	06/01/2023

PAYABLE THROUGH DRAFT

One Thousand One& 40 / 100 DOLLARS

VOID

AMOUNT
**********$1,001.40

VOID AFTER 180 DAYS

TO THE ORDER OF

UT BCDO SPECIALTY DENTAL SERVICES, PLLC
BURG CHILDRENS DENTISTRY & ORT
3401 N CENTER ST STE 250
LEHI UT 84043

NON-NEGOTIABLE

⑈296422750⑈ ⑆044115126⑆ ⑈0166950861 2⑈