38.00

1 OF 2 F

Guardian PO BOX 981572 EL PASO, TX 79998-1572

Electronic Service Requested

ALL FOR AADC 840

30298 0.5738 AB 0.504

IVR32 LATMAG YTLAID392 OGOB TU LOS 3TZ GR GOOWG3R Z 5588 LEEP-88048 TU rNAGROL TZ3W

If you have any (800) 541-7846

questions contact: WWW.GUARDIANANYTIME.COM

BRADLEY J SMITH Provider:

05/16/23 Date:

UT BCDO SPECIALTY DENTAL SER Payee:

38.00

Check No.: 187889273 **Payment Amount:** \$472.00

38.00

Expedite cash flow with e-payments. Sign up today!

Guardian has contracted with Change Healthcare, a leading provider of revenue and payment cycle solutions, to deliver Electronic Funds Transfer (EFT) services! Sign-up today by going to www.changehealthcare.com/support /customer-resources/enrollment-services for more information. Enrollment for this service is offered to you at no additional cost and is available online or by calling 1.866.777.0713 and selecting Option 1.

PROVIDER EXPLANATION OF BENEFITS - THIS IS NOT A BILL

Important! Please examine this statement for accuracy. Save this statement for tax purposes.

Patient Account No.: 120371633 Claim Number: 27129F13500 **Plan Number:** 00042176 MARILYN LARKIN **Employee Name:** DANIEL LARKIN Patient Name: **Relationship:** DAUGHTER SPEED OF LIGHT OPS, LLC Planholder: Line Submitted Alt Tooth Date of Submitted Considered Covered Deductible Coverage Benefit ADA Codes/Description Code No. Service Charge Charge Charge **Amount** Percent Amount No. 05/11/23 D0120/Periodic Eval FM 39.00 23.00 100% 23.00 23.00 D1206/Fluoride Varn 05/11/23 36.00 15.00 15.00 FM 100% 15.00

75.00

BENEFIT SUMMARY

0.00

\$38.00
\$38.00
\$0.00
\$0.00
\$ 38.00
\$0.00

Remarks for claim # 27129F13500:

REIMBURSEMENT HAS BEEN DETERMINED USING A STRATOSE/TDA FEE SCHEDULE

TOTALS

Pati	m Number: 27128F13500 ent Name: ANDREW L speed of L		Employee	Patient Account No.: 120371632 Employee Name: DANIEL LARKIN				Plan Number: 00042176 Relationship: SON		
Line		Alt Code	Tooth No.	Date of Service	Submitted	Charge	Covered	Deductible	Coverage	Benefit
No.	ADA Codes/Description	Code	110.	Service	Charge	Charge	Charge	Amount	Percent	Amount
1	D0120/Periodic Eval		FM	05/11/23	39.00	23.00	23.00		100%	23.00

The Guardian Life Insurance 10 Hudson Yards **Company of America** New York, NY 10001

CHECK NO: 187889273 **CHECK DATE: 05/16/23**

51-44 **AMOUNT** ****\$472.00

Void unless presented within 180 days

BANK OF AMERICA 150 WINDSOR STREET, HARTFORD, CT 06120

TO THE

ORDER OF

PAY Four Hundred Seventy Two Dollars

UT BCDO SPECIALTY DENTAL SERVI

ENV-30298

S Guardian PO BOX 981572 EL PASO TX 79998-1572

> If you have any questions contact:

(800) 541-7846

WWW.GUARDIANANYTIME.COM

BRADLEY J SMITH Provider:

Date: 05/16/23

UT BCDO SPECIALTY DENTAL SER Payee:

Check No.: 187889273 \$472.00 **Payment Amount:**

Claim Number: 27128F13500 ANDREW LARKIN Patient Name:

Patient Account No.: 120371632

Plan Number: 00042176

Employee Name: DANIEL LARKIN Relationship: SON Planholder: SPEED OF LIGHT OPS, LLC Tooth Submitted Considered Coverage Submitted Date of Covered **Deductible** Benefit Line Alt ADA Codes/Description Code Charge No. Service Charge Charge Amount Percent Amount No. D0240/Occlusal Image FM 05/11/23 27.00 16.00 16.00 100% 16.00 3 D0240/Occlusal Image

27.00 05/11/23 100% 16.00 16.00 16.00 05/11/23 36.00 22.00 22.00 100% 22.00 05/11/23 52.00 35.00 35.00 100% 35.00 36.00 05/11/23 15.00 15.00 100% 15.00 217.00 127.00 127.00 0.00 127.00 TOTALS

BENEFIT SUMMARY

TOTAL BENEFIT PAYABLE	\$127.00
HIGHER ALLOWABLE	\$127.00
PAID BY OTHER INSURANCE	\$0.00
ADJUSTMENTS	\$0.00
TOTAL BENEFIT PAID	\$ 127.00
PATIENT'S RESPONSIBILITY	\$0.00

Remarks for claim # 27128F13500:

D0272/Bitewing - 2

D1120/Child Cleaning

D1206/Fluoride Varn

4

REIMBURSEMENT HAS BEEN DETERMINED USING A STRATOSE/TDA FEE SCHEDULE

FM

FM

FM

FM

			COLLIN LARKIN Employee Name: DANIEL LARKIN						Plan Number: 00042176 Relationship: SON			
Plan Line No.	Submitted ADA Codes/Description	Alt Code	OPS, LLO Tooth No.	Date of Service	Submitted Charge	Considered Charge	Covered Charge	Deductible Amount	Coverage Percent	Benefit Amount		
1	D0120/Periodic Eval		FM	05/11/23	39.00	25.00	23.00		100%	23.00		
2	D0240/Occlusal Image		FM	05/11/23	27.00	16.00	16.00		100%	16.00		
3	D0240/Occlusal Image		FM	05/11/23	27.00	16.00	16.00		100%	16.00		
4	D0272/Bitewing - 2		FM	05/11/23	36.00	22.00	22.00		100%	22.00		
5	D1120/Child Cleaning		FM	05/11/23	52.00	35.00	35.00		100%	35.00		
6	D1206/Fluoride Varn		FM	05/11/23	36.00	15.00	15.00		100%	15.00		
-		•	•	TOTALS	217.00	127.00	127.00		0.00	127.00		

BENEFIT SUMMARY

DENETTI SUN	11/1/11/1
TOTAL BENEFIT PAYABL	E \$127.00
HIGHER ALLOWABLE	\$127.00
PAID BY OTHER INSURAN	CE \$0.00
ADJUSTMENTS	\$0.00
TOTAL BENEFIT PAID	\$ 127.00
PATIENT'S RESPONSIBILI	TY \$0.00

Remarks for claim # 27126F13500:

REIMBURSEMENT HAS BEEN DETERMINED USING A STRATOSE/TDA FEE SCHEDULE

Claim 1 (amber: 2/12/113300				Employee	Patient Account No.: 120371631 Employee Name: DANIEL LARKIN				Plan Number: 00042176 Relationship: SON			
Line No.		Alt Code	Tooth No.	Date of Service	Submitted Charge	Considered Charge	Covered Charge	Deductible Amount	Coverage Percent	Benefit Amount		
1	D0120/Periodic Eval		FM	05/11/23	39.00	23.00	23.00		100%	23.00		
2	D0272/Bitewing - 2		FM	05/11/23	36.00	22.00	22.00		100%	22.00		
3	D1120/Child Cleaning		FM	05/11/23	52.00	35.00	35.00		100%	35.00		
4	D1206/Fluoride Varn		FM	05/11/23	36.00	15.00	15.00		100%	15.00		
5	D0330/Panoramic		FM	05/11/23	82.00	53.00	53.00		100%	53.00		
6	D0240/Occlusal Image		FM	05/11/23	27.00	16.00	16.00		100%	16.00		
7	D0240/Occlusal Image		FM	05/11/23	27.00	16.00	16.00		100%	16.00		

The Guardian Life Insurance Company of America

S Guardian PO BOX 981572 EL PASO TX 79998-1572

If you have any (800) 541-7846

questions contact: WWW.GUARDIANANYTIME.COM

Provider: BRADLEY J SMITH

Date: 05/16/23

Payee: UT BCDO SPECIALTY DENTAL SER

Check No.: 187889273 **Payment Amount:** \$472.00

Claim Number: 27127F13500 Patient Account No.:120371631 Plan Number:00042176

Patient Name: FOSTER LARKIN Employee Name: DANIEL LARKIN Relationship: SON

Plan	riannoider: Speed of Light Ops, LLC									
Line	Submitted	Alt	Tooth	Date of	Submitted	Considered	Covered	Deductible	Coverage	Benefit
No.	ADA Codes/Description	Code	No.	Service	Charge	Charge	Charge	Amount	Percent	Amount
		•		TOTALS	299.00	180.00	180.00		0.00	180.00

BENEFIT SUMMARY

2 OF 2 B

ENV-30298

TOTAL BENEFIT PAYABLE	\$180.00
HIGHER ALLOWABLE	\$180.00
PAID BY OTHER INSURANCE	\$0.00
ADJUSTMENTS	\$0.00
TOTAL BENEFIT PAID	\$ 180.00
PATIENT'S RESPONSIBILITY	\$0.00

Remarks for claim # 27127F13500:

REIMBURSEMENT HAS BEEN DETERMINED USING A STRATOSE/TDA FEE SCHEDULE

Comments:

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