P627402800G

Guardian PO BOX 981572
EL PASO, TX 79998-1572

The Guardian Life Insurance
Company of America

190127

Electronic Service Requested

ALL FOR AADC 840
30298 0.5738 AB 0.504

UT BCDO SPECIALTY DENTAL SERVI
8822 S REDWOOD RD STE 201
WEST JORDAN, UT 84088-9336

511

If you have any questions contact: (800) 541-7846
WWW.GUARDIANANYTIME.COM

Provider: BRADLEY J SMITH
Date: 05/16/23
Payee: UT BCDO SPECIALTY DENTAL SER
Check No.: 187889273
Payment Amount: $472.00

1 OF 2 F

ENV 30298

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.

Claim Number: 27129F13500 **Patient Account No.:** 120371633 **Plan Number:** 00042176
Patient Name: MARILYN LARKIN **Employee Name:** DANIEL LARKIN **Relationship:** DAUGHTER
Planholder: SPEED OF LIGHT OPS, LLC

Line No.	Submitted ADA Codes/Description	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	D1206/Fluoride Varn		FM	05/11/23	36.00	15.00	15.00		100%	15.00
				TOTALS	75.00	38.00	38.00		0.00	38.00

BENEFIT SUMMARY

TOTAL BENEFIT PAYABLE.....	$38.00
HIGHER ALLOWABLE.....	$38.00
PAID BY OTHER INSURANCE.....	$0.00
ADJUSTMENTS.....	$0.00
TOTAL BENEFIT PAID.....	$ 38.00
PATIENT'S RESPONSIBILITY.....	$0.00

Remarks for claim # 27129F13500:
REIMBURSEMENT HAS BEEN DETERMINED USING A STRATOSE/TDA FEE SCHEDULE

Claim Number: 27128F13500 **Patient Account No.:** 120371632 **Plan Number:** 00042176
Patient Name: ANDREW LARKIN **Employee Name:** DANIEL LARKIN **Relationship:** SON
Planholder: SPEED OF LIGHT OPS, LLC

Line No.	Submitted ADA Codes/Description	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

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

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

51-44
119

AMOUNT
****$472.00

Void unless presented within 180 days

PAY Four Hundred Seventy Two Dollars

TO THE ORDER OF **UT BCDO SPECIALTY DENTAL SERVI**

BANK OF AMERICA
150 WINDSOR STREET, HARTFORD, CT 06120

VOID

⑈187889273⑈ ⑆011900445⑆ 40355⑈

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ENV 30298

Claim Number: 27128F13500 **Patient Account No.:** 120371632 **Plan Number:** 00042176
Patient Name: ANDREW LARKIN **Employee Name:** DANIEL LARKIN **Relationship:** SON
Planholder: SPEED OF LIGHT OPS, LLC

Line No.	Submitted ADA Codes/Description	Alt Code	Tooth No.	Date of Service	Submitted Charge	Considered Charge	Covered Charge	Deductible Amount	Coverage Percent	Benefit Amount
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

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:
REIMBURSEMENT HAS BEEN DETERMINED USING A STRATOSE/TDA FEE SCHEDULE

Claim Number: 27126F13500 **Patient Account No.:** 120371630 **Plan Number:** 00042176
Patient Name: COLLIN LARKIN **Employee Name:** DANIEL LARKIN **Relationship:** SON
Planholder: SPEED OF LIGHT OPS, LLC

Line No.	Submitted ADA Codes/Description	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	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

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 # 27126F13500:
REIMBURSEMENT HAS BEEN DETERMINED USING A STRATOSE/TDA FEE SCHEDULE

Claim Number: 27127F13500 **Patient Account No.:** 120371631 **Plan Number:** 00042176
Patient Name: FOSTER LARKIN **Employee Name:** DANIEL LARKIN **Relationship:** SON
Planholder: SPEED OF LIGHT OPS, LLC

Line No.	Submitted ADA Codes/Description	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

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Payment Amount: $472.00

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Claim Number: 27127F13500
Patient Name: FOSTER LARKIN
Planholder: SPEED OF LIGHT OPS, LLC
Patient Account No.: 120371631
Employee Name: DANIEL LARKIN
Plan Number: 00042176
Relationship: SON

Line No.	Submitted ADA Codes/Description	Alt Code	Tooth No.	Date of Service	Submitted Charge	Considered Charge	Covered Charge	Deductible Amount	Coverage Percent	Benefit Amount
				TOTALS	299.00	180.00	180.00		0.00	180.00

BENEFIT SUMMARY

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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Log on to www.GuardianAnytime.com for instant access to clinical policy guidelines and benefits information for Guardian members. Verify eligibility, view benefits, check claim status and more!