18.00

169.00



Electronic Service Requested

ALL FOR AADC 840

2230 2.0203 AB 0.504

լհոլոհոգորդիմիժհմնյութվ||ԱրդիՍնորդի||հդիով|Ահոգնժ

UT BCDO SPECIALTY DENTAL SERVI 1275 E FORT UNION BLVD STE 100 MIDVALE, UT 84047-1890

If you have any (800) 541-7846

questions contact: WWW.GUARDIANANYTIME.COM

GREGORY BIDDULPH Provider:

Date: 06/21/23

UT BCDO SPECIALTY DENTAL SER Payee:

Check No.: 188598331 Payment Amount: \$844.00

18.00

169.00

18.00

169.00

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.: 121822383

06/15/23

TOTALS

Pati	m Number: 39353F16700 ent Name: JAMESON F holder: MCNEIL'S A			e Name: JA	21822383 AMESON PAF	RRISH		n Number:0 ationship: S		
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	D0150/Comprehensive			06/15/23	36.00	36.00	36.00		100%	36.00
2	D0272/Bitewing - 2			06/15/23	21.00	21.00	21.00		100%	21.00
3	D0330/Panoramic			06/15/23	58.00	58.00	58.00		100%	58.00
4	D1120/Child Cleaning			06/15/23	36.00	36.00	36.00		100%	36.00

18.00

169.00

RENEFIT SUMMARY

0.00

BENEFIT SCHWART	
TOTAL BENEFIT PAYABLE	\$169.00
HIGHER ALLOWABLE	\$169.00
PAID BY OTHER INSURANCE	\$0.00
ADJUSTMENTS	\$0.00
TOTAL BENEFIT PAID	\$ 169.00
PATIENT'S RESPONSIBILITY	\$0.00

Remarks for claim # 39353F16700:

D1206/Fluoride Varn

Benefits are based on use of non-contracted provider.

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

CHECK NO: 188598331 **CHECK DATE: 06/21/23**

51-44

AMOUNT ****\$844.00

> Void unless presented within 180 days

PAY Eight Hundred Forty Four Dollars

TO THE UT BCDO SPECIALTY DENTAL SERVI ORDER OF

BANK OF AMERICA 150 WINDSOR STREET, HARTFORD, CT 06120



EL PASO TX 79998-1572

If you have any questions contact: (800) 541-7846

WWW.GUARDIANANYTIME.COM

Provider:

GREGORY BIDDULPH

Date: 06/21/23

UT BCDO SPECIALTY DENTAL SER Payee:

Check No.: 188598331 \$844.00 Payment Amount:

Patient Account No.: 119232110 Claim Number: 33421F17100 **BROOKE ELLISON Employee Name:** JESSE J COLIBERT Patient Name:

Plan Number: 00047974 **Relationship:** DAUGHTER

Planholder: GODWIN MANUFACTURING COMPANY Submitted Date of Submitted Considered Covered Deductible Coverage Line Alt Tooth Benefit ADA Codes/Description Code Service Charge Charge Charge Amount Percent Amount No. No. 04/13/23 52.00 100% D0274/Bitewing - 4 FM 52.00 52.00 52.00 22.00 04/13/23 2 D0220/Periapical 1st FM 22.00 22.00 100% 22.00 04/13/23 19.00 3 19.00 19.00 D0230/Periapical Add FM 100% 19.00 4 D1120/Child Cleaning FM 04/13/23 52.00 52.00 52.00 100% 52.00 36.00 04/13/23 5 D1206/Fluoride Varn FM 36.00 36.00 100% 36.00 39.00 D0120/Periodic Eval FM 04/13/23 39.00 39.00 100% 39.00 220.00 220.00 220.00 TOTALS 0.00 220.00

BENEFIT SUMMARY

TOTAL BENEFIT PAYABLE	\$220.00
HIGHER ALLOWABLE	\$220.00
PAID BY OTHER INSURANCE	\$0.00
ADJUSTMENTS	\$0.00
TOTAL BENEFIT PAID	\$ 220.00
PATIENT'S RESPONSIBILITY	\$0.00

Remarks for claim # 33421F17100:

A non-contracted provider has been utilized.

Claim Number: 33422F17100 Patient Name: KEIGYN COLIBERT		T	Patient A Employee	ccount No.:11 Name: JI	18962767 ESSE J COLIB	Plan Number: 00047974 Relationship: SON				
Planholder: GODWIN MAN			ACTURI	NG COMPAN	JY,					
Line		Alt	Tooth	Date of	Submitted	Considered	Covered	Deductible	Coverage	Benefit
No.	ADA Codes/Description	Code	No.	Service	Charge	Charge	Charge	Amount	Percent	Amount
1	D0120/Periodic Eval		FM	04/06/23	39.00	39.00	39.00		100%	39.00
2	D0220/Periapical 1st		FM	04/06/23	22.00	22.00	22.00		100%	22.00
3	D0230/Periapical Add		FM	04/06/23	19.00	19.00	19.00		100%	19.00
4	D0274/Bitewing - 4		FM	04/06/23	52.00	52.00	52.00		100%	52.00
5	D1206/Fluoride Varn		FM	04/06/23	36.00	36.00	36.00		100%	36.00
6	D1120/Child Cleaning		FM	04/06/23	52.00	52.00	52.00		100%	52.00
				TOTALS	220.00	220.00	220.00		0.00	220.00

BENEFIT SUMMARY

DENETH SCHWART	
TOTAL BENEFIT PAYABLE	\$220.00
HIGHER ALLOWABLE	\$220.00
PAID BY OTHER INSURANCE	\$0.00
ADJUSTMENTS	\$0.00
TOTAL BENEFIT PAID	\$ 220.00
PATIENT'S RESPONSIBILITY	\$0.00

Remarks for claim # 33422F17100:

A non-contracted provider has been utilized.

Pati	m Number: 33420F17100 ent Name: PRESTON E tholder: GODWIN M		Patient A Employed ING COMPAN		19232224 ESSE J COLIB	BERT		n Number:0 ationship: S		
Line		Alt	Tooth	Date of	Submitted	Considered	Covered	Deductible	Coverage	Benefit
No.	ADA Codes/Description	Code	No.	Service	Charge	Charge	Charge	Amount	Percent	Amount
1	D0274/Bitewing - 4		FM	04/13/23	52.00	52.00	52.00		100%	52.00
2	D0220/Periapical 1st		FM	04/13/23	22.00	22.00	22.00		100%	22.00
3	D0230/Periapical Add		FM	04/13/23	19.00	19.00	19.00		100%	19.00
4	D1110/Adult Cleaning		FM	04/13/23	67.00	67.00	67.00		100%	67.00
5	D1206/Fluoride Varn		FM	04/13/23	36.00	36.00	36.00		100%	36.00
6	D0120/Periodic Eval		FM	04/13/23	39.00	39.00	39.00		100%	39.00

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

GREGORY BIDDULPH Provider:

Date: 06/21/23

UT BCDO SPECIALTY DENTAL SER Payee:

Check No.: 188598331 \$844.00 **Payment Amount:**

Patient Account No.: 119232224 33420F17100 Claim Number: Plan Number: 00047974 Patient Name: PRESTON ELLISON **Employee Name:** JESSE J COLIBERT **Relationship:** SON

Plan	Planholder: GODWIN MANUFACTURING COMPANY,									
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
	*					8				
				TOTALS	235.00	235.00	235.00		0.00	235.00

BENEFIT SUMMARY

DEI (ETTT SCI.IIIITT	
TOTAL BENEFIT PAYABLE	\$235.00
HIGHER ALLOWABLE	\$235.00
PAID BY OTHER INSURANCE	\$0.00
ADJUSTMENTS	\$0.00
TOTAL BENEFIT PAID	\$ 235.00
PATIENT'S RESPONSIBILITY	\$0.00

Remarks for claim # 33420F17100:

A non-contracted provider has been utilized.

Comments:

Current Dental Terminology © 2021 American Dental Association. All rights reserved.

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!

5 OF 9 B