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Guardian PO BOX 981572
EL PASO, TX 79998-1572

The Guardian Life Insurance Company of America

Electronic Service Requested

ALL FOR AADC 840
2230 2.0203 AB 0.504

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

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

Provider: GREGORY BIDDULPH
Date: 06/21/23
Payee: UT BCDO SPECIALTY DENTAL SER
Check No.: 188598331
Payment Amount: $844.00

4 OF 9 F

ENV 2230

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: 39353F16700 **Patient Account No.:** 121822383 **Plan Number:** 00046017
Patient Name: JAMESON PARRISH **Employee Name:** JAMESON PARRISH **Relationship:** SON
Planholder: MCNEIL'S AUTO CARE

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
5	D1206/Fluoride Varn			06/15/23	18.00	18.00	18.00		100%	18.00
				TOTALS	169.00	169.00	169.00		0.00	169.00

BENEFIT SUMMARY

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:
Benefits are based on use of non-contracted provider.

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

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

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119

AMOUNT
****$844.00

Void unless presented within 180 days

PAY Eight Hundred Forty Four Dollars

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

BANK OF AMERICA
150 WINDSOR STREET, HARTFORD, CT 06120

VOID

⑈188598331⑈ ⑆011900445⑆ 40355⑈

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EL PASO TX 79998-1572

The Guardian Life Insurance
Company of America

[redacted]

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WWW.GUARDIANANYTIME.COM

Provider: GREGORY BIDDULPH
Date: 06/21/23
Payee: UT BCDO SPECIALTY DENTAL SER
Check No.: 188598331
Payment Amount: $844.00

Claim Number: 33421F17100 **Patient Account No.:** 119232110 **Plan Number:** 00047974
Patient Name: BROOKE ELLISON **Employee Name:** JESSE J COLIBERT **Relationship:** DAUGHTER
Planholder: GODWIN MANUFACTURING COMPANY,

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	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	D1120/Child Cleaning		FM	04/13/23	52.00	52.00	52.00		100%	52.00
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
				TOTALS	220.00	220.00	220.00		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 Account No.:** 118962767 **Plan Number:** 00047974
Patient Name: KEIGYN COLIBERT **Employee Name:** JESSE J COLIBERT **Relationship:** SON
Planholder: GODWIN MANUFACTURING COMPANY,

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	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

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.

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

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	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

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Provider: GREGORY BIDDULPH
Date: 06/21/23
Payee: UT BCDO SPECIALTY DENTAL SER
Check No.: 188598331
Payment Amount: $844.00

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

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	235.00	235.00	235.00		0.00	235.00

BENEFIT SUMMARY

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:

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!