LIBERTY Dental Plan
PO Box 26110
Santa Ana, CA 92799

PAYMENT DETAILS

VENDOR NAME: **Angela Pitts DMD PLLC**
VENDOR NUMBER: EV1950657

Check Number: PDF
Check Date: 12/06/2023

#	Date Of Service	Code	Tooth #	Surface	Procedure Description	Submitted Amount	Allowed Amount	Co-Pay Amt	Deductible	Co-Ins Amt	Total*	Plan Paid Amount
OFFICE: **Premier Dental Studio of Katy, #EV1950657 -** Address: 6940 Katy Gaston Rd Ste 200, Katy, TX 77494-6480												
Patient: **Dorothy Itn. ..... - Du9Jf9-01**					**Plan**: Devoted Health Comprehensive			**Group**: Devoted GIVEBACK Greater Houston				
CLAIM: **48508806** (Original)												
1	11/08/23	D4341	Q20		Periodontal scaling and root planing, four or more teeth per quadrant	311.00	135.00	0.00	0.00	0.00	0.00	135.00
2	11/08/23	D4341	Q30		Periodontal scaling and root planing, four or more teeth per quadrant	311.00	135.00	0.00	0.00	0.00	0.00	135.00
3	11/10/23	D4341	Q10		Periodontal scaling and root planing, four or more teeth per quadrant	311.00	135.00	0.00	0.00	0.00	0.00	135.00
4	11/10/23	D4341	Q40		Periodontal scaling and root planing, four or more teeth per quadrant	311.00	135.00	0.00	0.00	0.00	0.00	135.00
					CLAIM TOTALS:	1,244.00	540.00	0.00	0.00	0.00	0.00	540.00
												*Amount due from patient
CLAIM: **48509024** (Original)												
1	11/29/23	D9944			Occlusal guard, hard appliance, full arch	679.00	398.00	0.00	0.00	0.00	0.00	398.00
					CLAIM TOTALS:	679.00	398.00	0.00	0.00	0.00	0.00	398.00
												*Amount due from patient
					NET PAYMENT FOR PATIENT :							**938.00**
Patient: **Felton,Thomas Deerky-01**					**Plan**: Devoted Health Comprehensive			**Group**: Devoted CORE Greater Houston				
CLAIM: **48509655** (Original)												
1	11/17/23	D5110	Q01		Complete denture, maxillary	2,125.00	743.00	0.00	0.00	0.00	0.00	743.00
					CLAIM TOTALS:	2,125.00	743.00	0.00	0.00	0.00	0.00	743.00
												*Amount due from patient
					NET PAYMENT FOR PATIENT :							**743.00**
Patient: **Lundquist, Ponder- Dwhs2W-01**					**Plan**: Devoted Health Comprehensive			**Group**: Devoted PRIME Greater Houston				
CLAIM: **48510521** (Original)												
1	10/18/23	D2740	31		Crown, porcelain/ceramic	1,350.00	739.00	0.00	0.00	0.00	0.00	739.00
2	10/18/23	D2950	31		Core buildup, including any pins when required	325.00	139.00	0.00	0.00	0.00	0.00	139.00
					CLAIM TOTALS:	1,675.00	878.00	0.00	0.00	0.00	0.00	878.00
												*Amount due from patient
					NET PAYMENT FOR PATIENT :							**878.00**
Patient: **Mehta Vikky - Dwgra8-01**					**Plan**: Devoted Health Comprehensive			**Group**: Devoted CORE Greater Houston				
CLAIM: **48509099** (Original)												

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1	07/12/23	D4341	Q20		Periodontal scaling and root planing, four or more teeth per quadrant	311.00	135.00	0.00	0.00	0.00	0.00	135.00
2	07/12/23	D4341	Q30		Periodontal scaling and root planing, four or more teeth per quadrant	311.00	135.00	0.00	0.00	0.00	0.00	135.00
					CLAIM TOTALS:	622.00	270.00	0.00	0.00	0.00	0.00	270.00

**Amount due from patient*

NET PAYMENT FOR PATIENT : 270.00

Patient **Houn , Teng - Dsckfs-01** **Plan**: Devoted Health Comprehensive **Group**: Devoted PRIME Greater Houston

CLAIM: **48509100** (Original)

#	Date Of Service	Code	Tooth #	Surface	Procedure Description	Submitted Amount	Allowed Amount	Co-Pay Amt	Deductible	Co-Ins Amt	Total*	Plan Paid Amount
1	11/22/23	D7210	3		Extraction, erupted tooth requiring removal o bone and/or sectioning of tooth	348.00	145.00	0.00	0.00	0.00	0.00	145.00
					CLAIM TOTALS:	348.00	145.00	0.00	0.00	0.00	0.00	145.00

**Amount due from patient*

NET PAYMENT FOR PATIENT : 145.00

TOTALS PER OFFICE

Original Claims:	2,974.00
Interest:	0.00
Adiustments:	0.00
GRAND TOTALS PER OFFICE:	**2,974.00**

VENDOR TOTALS:	6,693.00	2,974.00	0.00	0.00	0.00	0.00	**2,974.00**

NET PAYMENT : 2,974.00

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IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

HOW DO I FILE AN APPEAL?

CONTRACTED PROVIDERS

Contracted providers participating in provider network(s) for Medicare Advantage plans may request an appeal of a denial determination. Appeals must be submitted within 90 days of the date on this remittance advice.

LIBERTY Dental Plan
Quality Management Department
ATTN: Grievance and Appeals
P.O. Box 26110
Santa Ana, CA 92799-6110
Or Fax: (949) 270-0109

NON-CONTRACTED PROVIDERS

For non-participating providers: If you have received a denial on your claim and would like to appeal the decision, please do so within 60 days from the date of your remittance as we are unable to consider any appeal request after the 60-day limit has expired. Please send your request and all supporting documentation, including the Waiver of Liability form, which can be found at www.devoted.com/providers/ to the following address:

Devoted Health Inc.
Attn: Provider Appeals
PO Box 21327
Eagan, MN 55121

Reminder: Appeals cannot be considered without the valid Waiver of Liability form.

SUBMISSION PROCESS

Appeals and requests for reconsideration of a denial determination must be submitted in writing to the appropriate address identified above and include a minimum: a summary of the appeal or reconsideration request, the member's name, member's identification number, date of service(s), reason(s) why the denial should be reversed and copies of related documentation and/or applicable medical records to support appropriateness of the services rendered.

We must give you a decision no later than 30 calendar days after we receive our request.

All other claim inquiries should be sent to:

LIBERTY Dental Plan
P.O. Box 401086
Las Vegas, NV 89140