DELTA DENTAL

DELTA DENTAL OF VIRGINIA
PO BOX 103
STEVENS POINT WI 54481-0103

Inquiries: 888-899-3734
www.deltadentalcoversme.com
Date: 08/10/2020

MATTHEW T FREELAND
2084 GILLEN LN
FALLS CHURCH, VA 22043

Claim Number: 2-0220-314-56
Group Name: VA Individual # 888-899-3734
Subscriber: MATTHEW T FREELAND
Subscriber ID#: XXXXX5035
Patient: MATTHEW T FREELAND
Dentist: PAUL E LEVINE

Other Carrier Paid: 0.00

EXPLANATION OF BENEFITS ** THIS IS NOT A BILL **

TH	SURF	Service Date	Proc. Code	Procedure Description	Submit Amt	Fee Adjust	Approved Amt	Allowed Amt	Deduct Applied	Coverage Percent	Patient Payment	Benefit Payment	Ref. Code
		08/06/2020	120	Evaluation	70.00	26.00	44.00	44.00	44.00	100	44.00	0.00	
		08/06/2020	274	Bitewings-4	75.00	25.00	50.00	50.00	6.00	100	6.00	44.00	
		08/06/2020	1110	Cleaning	125.00	46.00	79.00	79.00	0.00	100	0.00	79.00	
				TOTALS	270.00	97.00	173.00	173.00	50.00		50.00	123.00	

Payment To	Date	Check Number	Check Amount
DR. PAUL E LEVINE	20200812	4015029	123.00

For Benefit Year: 01/01/2020-12/31/2020

The amount applied to this individual's benefit year deductible is: $50.00
The amount applied to this individual's annual benefit year maximum is: $123.00
The amount applied to this individual's out-of-pocket limit is: $.00

Reference Codes

Because you are seeing a Delta dentist, you are responsible to pay only the amount indicated in the patient payment column.

Payment for these services is determined in accordance with the specific terms of your dental plan or of Delta Dental's agreement with Delta Dental network dentists.

You may access Delta Dental's Notice of Privacy Practices on our website at www.DeltaDentalCoversMe.com/Disclosures. You may also obtain a hard copy of these notices by contacting our compliance administrator at 888-899-3734.

To submit a claim with intent to defraud an insurer is a crime. If you wish to report suspected fraud or abuse of dental care benefits please contact Delta Dental's professional services department at ps@deltadentalcoversme.com.

RIGHTS OF REVIEW AND APPEAL

If you have questions about your claim, please contact the Dental Benefit Center at 888.899.3734. Because most questions about benefits can be answered informally, we encourage you first to try resolving any problem by talking with us. If the matter cannot be resolved informally, you have the right to request that we formally review the claims decision. To file a request for review:

Make your request by calling us at 888-899-3734, faxing us at 800-807-1970, or mailing your request to Delta Dental, P.O. Box 103, Stevens Point, WI 54481-0103. Provide the reasons why you disagree with the claims decision and include any documentation you believe supports your claim. Be sure to include the patient's name, subscriber's name and subscriber's ID number on all supporting documents.

We will acknowledge your written request for review within 5 days of receiving it.

Upon your request, we will provide you, free of charge, access to and copies of all documents, records and other information relevant to your claim for benefits.

Within 30 days of receiving your request, we will send you our written decision and indicate any action we've taken. (Special circumstances may require 60 days.)