UnitedHealthcare®
A UnitedHealth Group Company
PO Box 30567
Salt Lake City, UT 84130-0567

[EP-EP]

EXPLANATION OF DENTAL PLAN REIMBURSEMENT THIS IS NOT A BILL

Forwarding Service Requested

J7BD 482,175

SPANISH SPRINGS MODERN DENTIST
PO BOX 920050
DALLAS TX 75392

This payment has been processed electronically either by means of your registered bank account or by Virtual Credit Card. In the instance that you have received a paper check, if you have questions, please contact Zelis.

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EXPLANATION OF DENTAL PLAN REIMBURSEMENT THIS IS NOT A BILL

Page 3 of 4
Date: 07/24/2025

SPANISH SPRINGS MODERN DENTIST
PO BOX 920050
DALLAS TX 75392

PROVIDER OR MBR NAME AND ID NO; PROVIDER NETWORK STATUS; GROUP NO; CLAIM NO ADA CODE DESCRIPTION	DATE OF SERVICE	TOOTH NO	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID	EOB CODE
MICHELLE JANCSO NPI Submitted: 1942857792 HEIRES, MARYLOU 99746734300; Out of Network; 18256780; 251782908800									
ADA CODE D0330 panoramic radiographic image	07/21/25	01 32	$145.00	$0.00	$0.00	$0.00	$145.00	$0.00	B05
ADA CODE D0150 comprehensive oral evaluation - new or established patient	07/21/25	01 32	$145.00	$36.00	$0.00	$0.00	$109.00	$36.00	PSC
ADA CODE D0210 intraoral - comprehensive series of radiographic images	07/21/25	01 32	$167.00	$80.00	$0.00	$0.00	$87.00	$80.00	PSC
ADA CODE D0350 2D Oral/facial photographic images obtained intraorally or extraorally	07/21/25	01 32	$102.00	$0.00	$0.00	$0.00	$102.00	$0.00	PS0
ADA CODE D0350 2D Oral/facial photographic images obtained intraorally or extraorally	07/21/25	01 32	$102.00	$0.00	$0.00	$0.00	$102.00	$0.00	PS0
ADA CODE D0350 2D Oral/facial photographic images obtained intraorally or extraorally	07/21/25	01 32	$102.00	$0.00	$0.00	$0.00	$102.00	$0.00	PS0
ADA CODE D0350 2D Oral/facial photographic images obtained intraorally or extraorally	07/21/25	01 32	$102.00	$0.00	$0.00	$0.00	$102.00	$0.00	PS0
ADA CODE D0367 cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	07/21/25	01 32	$404.00	$0.00	$0.00	$0.00	$404.00	$0.00	PS0
SUB-TOTAL			$1,269.00	$116.00	$0.00	$0.00	$1,153.00	$116.00	

Notes:

PS0 This service is not covered under your plan

PSC The charge exceeds the allowable amount for this procedure.

B05 Payment is included in the allowance for another service/procedure.

[EP-EP]

PROVIDER OR MBR NAME AND ID NO; PROVIDER NETWORK STATUS; GROUP NO; CLAIM NO ADA CODE DESCRIPTION	DATE OF SERVICE	TOOTH NO	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID	EOB CODE
MICHELLE JANCSO NPI Submitted: 1942857792 HEIRES, MARYLOU 99746734300; Out of Network; 18256780; 251783783200									
ADA CODE D4921 gingival irrigation with a medicinal agent - per quadrant	07/21/25	01 08	$86.00	$0.00	$0.00	$0.00	$86.00	$0.00	PS0
ADA CODE D4921 gingival irrigation with a medicinal agent - per quadrant	07/21/25	09 16	$86.00	$0.00	$0.00	$0.00	$86.00	$0.00	PS0
ADA CODE D4921 gingival irrigation with a medicinal agent - per quadrant	07/21/25	17 24	$86.00	$0.00	$0.00	$0.00	$86.00	$0.00	PS0
ADA CODE D4921 gingival irrigation with a medicinal agent - per quadrant	07/21/25	25 32	$86.00	$0.00	$0.00	$0.00	$86.00	$0.00	PS0
ADA CODE D4910 periodontal maintenance	07/21/25	01 32	$227.00	$76.00	$0.00	$0.00	$151.00	$76.00	PSC
ADA CODE D4999 unspecified periodontal procedure, by report	07/21/25	01 32	$250.00	$0.00	$0.00	$0.00	$250.00	$0.00	PSC
ADA CODE D1206 topical application of fluoride varnish	07/21/25	01 32	$115.00	$26.00	$0.00	$0.00	$89.00	$26.00	PSC
ADA CODE D1330 oral hygiene instructions	07/21/25	01 32	$95.00	$0.00	$0.00	$0.00	$95.00	$0.00	PSC
SUB-TOTAL			$1,031.00	$102.00	$0.00	$0.00	$929.00	$102.00	

Notes:

PSC The charge exceeds the allowable amount for this procedure.

PS0 This service is not covered under your plan

	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID
TOTAL	$2,300.00	$218.00	$0.00	$0.00	$2,082.00	$218.00

Attention Non-contracted Medicare Providers

Appeals Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination including issues related to bundling or downcoding of services. To appeal a claim denial, submit a written request within 65 calendar days of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for appeal
- A signed Waiver of Liability form (you may obtain a copy by going to https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip)
- A copy of the original claim
- A copy of the remittance notice showing the claim denial
- Any additional information, clinical records or documentation

Mail the appeal request to: UnitedHealthcare P.O. Box 6106, Cypress, CA 90630 MS:CA124-0157

Payment Dispute Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider disagrees with the amount paid. To dispute a claim, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for the dispute
- A copy of the original claim
- A copy of the remittance notice showing the claim payment
- Any additional information, clinical records or documentation to support the dispute

Mail the payment dispute to:

Claim Adjustment Department
PO Box 31364
Salt Lake City, UT 84130

Billing Alerts

Section 1905(n) of the Social Security Act prohibits a provider from billing an individual with coverage as a Qualified Medicare Beneficiary (QMB), with or without other Medicaid coverage, or someone receiving Supplemental Security Income benefits and Medicare for the Medicare deductible or coinsurance.

(For Contracted Network Providers – see next page)

Attention Contracted Medicare Providers

Appeals

- Pre-Service Appeals – appeal of a prior authorization decision to deny coverage.

To appeal a pre-service denial, submit a written request within 65 calendar days of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for appeal
- A copy of the original pre-service request
- A copy of the remittance notice showing the denial
- Any additional information, clinical records or documentation

Submit to the following address:
Appeals and Grievance Department
PO Box 6106, MS CA124-0157
Cypress, CA 90630

Claim Reconsideration / Payment Dispute Requests

- Reconsideration requests – adjustment request due to billing or processing error.
- Payment disputes – disagreement with rate or paid amount on claim. Member is not liable in excess of normal cost share.

To request claim reconsideration or to dispute a payment, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for the dispute
- A copy of the original claim
- A copy of the remittance notice showing the claim payment
- Any additional information, clinical records or documentation to support the dispute

Submit to the following address:
Claim Adjustment Department
PO Box 30569
Salt Lake City, UT 84130-0569

(PRMC02v4)