DELTA DENTAL

P.O. Box 1803
Alpharetta, GA 30023

June 14, 2024

Plan underwritten by:
Delta Dental of California

Plan administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023

CAN WE HELP?
Visit our website:
deltadentalins.com

Call Customer Service: **866-774-5595**
Hearing Impaired: TTY **7-1-1**
Mon. to Fri., 5 a.m. to 6 p.m. Pacific Time

DC043436 BRENTWOOD SMILES DENTISTRY
PO BOX 920050
DALLAS TX 75392-0050

DC043436 BRENTWOOD SMILES DENTISTRY
Facility number: 043436
Tax ID number: XXXXXX7754

The claims listed in this document have been adjusted

We have reprocessed the submitted services based on additional information received as shown in the details of each claim, resulting in an overpayment.

If indicated in the claim details, we will begin to automatically deduct the overpaid amount from a future payment but no sooner than 45 days from the date on this notification. If you choose to manually refund this overpayment by sending Delta Dental a check, please send your payment to Delta Dental at the address above within the next 45 days to ensure it is applied to your account prior to the automatic deduction.

No action is required from you at this time unless you wish to refund this overpayment or contest the adjustment. To contest the adjustment, please complete and submit a Provider Inquiry Form within 45 days of this notice. This form is available on our website at deltadentalins.com/dentists.

This Claim Statement/Payment is being mailed in place of your normal Electronic Remittance Advice (ERA 835) because one or more submitted claim(s) could not be processed electronically through your clearinghouse process. This is usually due to an out-of-balance record that could not be adjusted with a standard HIPAA compliant remittance code.

A dentist may not bill or collect from a member any charges in connection with a non-covered dental service unless an executed financial responsibility form has been obtained from the member or the member's legal representative prior to performing the services.

Summary of claim information

PATIENT NAME	MEMBER ID NUMBER	DATE OF SERVICE	CLAIM NUMBER	PATIENT COPAY ($)	DELTA DENTAL PAYS ($)
ALESSANDRA N MONTES	2729673013-04	February 8, 2024	202402147487243	0.00	-37.50
ALESSANDRA N MONTES	2729673013-04	March 8, 2024	202403138898718	0.00	-37.50
ALESSANDRA N MONTES	2729673013-04	April 8, 2024	202404104001383	0.00	-37.50
ALESSANDRA N MONTES	2729673013-04	May 8, 2024	202405086539079	0.00	-37.50

Claim details

Patient: ALESSANDRA N MONTES

Relationship: Dependent
Date of birth: January 17, 2009
Group name: CONTRA COSTA COUNTY
Group number: 71482-00001

Primary member: GREGORY J MONTES
Member ID numbers: 2729673013-04

1 Claim number: 202402147487243

PROCEDURE NUMBER AND TYPE OF SERVICE	SUBMITTED FEE ($)	ACCEPTED FEE ($)	NOT COVERED ($)	PAID BY ANOTHER PLAN ($)	PATIENT COPAY ($)	PATIENT PAYS ($)	DELTA DENTAL PAYS ($)
Date of service: February 8, 2024							
Treatment type: Orthodontics							
(D8670) PERIODIC ORTHODONTIC TREATMENT VISIT	-37.50	-37.50	0.00	--	0.00	0.00	-37.50
				Treating provider: DC043436 BRENTWOOD SMILES DENTISTRY			

▶ NOTE: (861) Monthly orthodontic installment payments are automatically issued over the course of treatment. No further action is required. The payments are already scheduled to be issued subject to the patient's continued eligibility and contract maximum.
(9J3) This service has been voided and the payment has been adjusted accordingly.
(ZZA) The returned monies have been received no further action required.

Claim total for ALESSANDRA N MONTES	**-37.50**	**-37.50**	**0.00**	**0.00**	**0.00**	**0.00**	**-37.50**

2 Claim number: 202403138898718

PROCEDURE NUMBER AND TYPE OF SERVICE	SUBMITTED FEE ($)	ACCEPTED FEE ($)	NOT COVERED ($)	PAID BY ANOTHER PLAN ($)	PATIENT COPAY ($)	PATIENT PAYS ($)	DELTA DENTAL PAYS ($)
Date of service: March 8, 2024							
Treatment type: Orthodontics							
(D8670) PERIODIC ORTHODONTIC TREATMENT VISIT	-37.50	-37.50	0.00	--	0.00	0.00	-37.50
				Treating provider: DC043436 BRENTWOOD SMILES DENTISTRY			

▶ NOTE: (861) Monthly orthodontic installment payments are automatically issued over the course of treatment. No further action is required. The payments are already scheduled to be issued subject to the patient's continued eligibility and contract maximum.
(9J3) This service has been voided and the payment has been adjusted accordingly.
(ZZA) The returned monies have been received no further action required.

Claim total for ALESSANDRA N MONTES	**-37.50**	**-37.50**	**0.00**	**0.00**	**0.00**	**0.00**	**-37.50**

3 Claim number: 202404104001383

Your adjusted claims statement

Date: June 14, 2024

Patient: ALESSANDRA N MONTES (continued)

PROCEDURE NUMBER AND TYPE OF SERVICE	SUBMITTED FEE ($)	ACCEPTED FEE ($)	NOT COVERED ($)	PAID BY ANOTHER PLAN ($)	PATIENT COPAY ($)	PATIENT PAYS ($)	DELTA DENTAL PAYS ($)
Date of service: April 8, 2024							
Treatment type: Orthodontics							
(D8670) PERIODIC ORTHODONTIC TREATMENT VISIT	-37.50	-37.50	0.00	--	0.00	0.00	-37.50
				Treating provider: DC043436 BRENTWOOD SMILES DENTISTRY			

▶ NOTE: (861) Monthly orthodontic installment payments are automatically issued over the course of treatment. No further action is required. The payments are already scheduled to be issued subject to the patient's continued eligibility and contract maximum.
(9J3) This service has been voided and the payment has been adjusted accordingly.
(ZZA) The returned monies have been received no further action required.

Claim total for ALESSANDRA N MONTES	**-37.50**	**-37.50**	**0.00**	**0.00**	**0.00**	**0.00**	**-37.50**

4 **Claim number:** 202405086539079

PROCEDURE NUMBER AND TYPE OF SERVICE	SUBMITTED FEE ($)	ACCEPTED FEE ($)	NOT COVERED ($)	PAID BY ANOTHER PLAN ($)	PATIENT COPAY ($)	PATIENT PAYS ($)	DELTA DENTAL PAYS ($)
Date of service: May 8, 2024							
Treatment type: Orthodontics							
(D8670) PERIODIC ORTHODONTIC TREATMENT VISIT	-37.50	-37.50	0.00	--	0.00	0.00	-37.50
				Treating provider: DC043436 BRENTWOOD SMILES DENTISTRY			

▶ NOTE: (861) Monthly orthodontic installment payments are automatically issued over the course of treatment. No further action is required. The payments are already scheduled to be issued subject to the patient's continued eligibility and contract maximum.
(9J3) This service has been voided and the payment has been adjusted accordingly.
(ZZW) This statement reflects a negative balance. If you wish to dispute this balance, you may submit your dispute in writing or visit the website address printed on the front of this statement for more information or, you may return the amount of the negative balance to the address on this statement.

Claim total for ALESSANDRA N MONTES	**-37.50**	**-37.50**	**0.00**	**0.00**	**0.00**	**0.00**	**-37.50**

Upon request and free of charge, Delta Dental will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination.

Delta Dental takes fraud seriously.

Learn how you can protect your practice from fraud at deltadentalins.com/dentists.