



P.O. Box 997330
Sacramento, CA 95899-7330

AV 01 127979 83982H502 A**5DGT



SUVIDHA KHATRI
30949 COURTHOUSE DR
UNION CITY CA 94587-1716

July 17, 2025

Plan administered by:
Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

CAN WE HELP?
Visit our website:
deltadentalins.com

Call Customer Service: 888-335-8227
TDD/TTY 800-735-2922

Mon to Fri 8 a.m. to 8 p.m. Pacific Time

15770

127979 1/2

SUVIDHA KHATRI
Tax ID number: XXXXXX9027

Your claims summary

Total amount of claims	\$0.00
Amount patient pays	\$0.00
Interest paid	\$0.00
Less any adjustments	\$0.00
Amount Delta Dental pays	\$0.00

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.

Have you advised your patient about reasonable post-surgical pain expectations and management?

In the management of post-surgical discomfort, the use of non-opioid pain relievers may be sufficient.

Consider the use of short duration opioid prescriptions when there is a need to manage pain relief for a limited time basis.

According to the Center for Disease Control and prevention in 2016, 42,249 people died from an opioid overdose.

No payment has been made on the claims listed in this document

We have processed the submitted services as shown in the details of each claim. Please carefully review the details that explain the reason that no payment is being made.

The amounts shown as payable by Delta Dental and the patient are in accordance with the terms of the patient's dental plan and the terms of our agreement with you, if you are a Delta Dental participating or contracting dental provider.

You have the right to file a dispute with Delta Dental of California regarding our determination of the claims shown on this document. Please visit our web site shown above for instructions on how to file a dispute. You may still contact us to ask for a re-evaluation or other inquiries, even if you choose to file a dispute.



071725CACAPEOBTA-2934

Summary of claim information

PATIENT NAME	MEMBER ID NUMBER	DATE OF SERVICE	CLAIM NUMBER	PATIENT PAYS (\$)	DELTA DENTAL PAYS (\$)
KELVIN HOLMES JR	1198814058-02	June 26, 2025	202507097638648	0.00	0.00

Claim details

Patient: KELVIN HOLMES JR

Relationship: Dependent

Date of birth: April 12, 2000

Group name: UCBT ACTIVES PREMIER - PLAN A

Group number: 20497-00450

Primary member: MARQUITA L HOLMES

Member ID numbers: 1198814058-02

1 Claim number: 202507097638648

PROCEDURE NUMBER AND TYPE OF SERVICE TOOTH NUMBER AND SURFACE	SUBMITTED FEE (\$)	ACCEPTED FEE (\$)	MAXIMUM CONTRACT ALLOWANCE (\$)	AMOUNT APPLIED TO DEDUCTIBLE (\$)	PAID BY ANOTHER PLAN (\$)	CONTRACT BENEFIT LEVEL	PATIENT PAYS (\$)	DELTA DENTAL PAYS (\$)
Date of service: June 26, 2025 Treatment type: Diagnostic (D0220) INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	0.00	0.00	0.00	0.00	--	0%	0.00	0.00

Treating provider: SUVIDHA KHATRI

- NOTE: (743) The member has met the annual contractual maximum. The patient is responsible for the amount indicated as "Patient Pays."
 (804) Benefits have been adjusted based on the non-duplication of benefits provision of the enrollee's program. If this coverage is secondary, the actual payment may be less than the amount estimated.

Date of service: June 26, 2025

Treatment type: Restorative

(D2950) CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED

Tooth: 12

0.00 0.00 0.00 0.00 -- 0% 0.00 0.00

Treating provider: SUVIDHA KHATRI

- NOTE: (743) The member has met the annual contractual maximum. The patient is responsible for the amount indicated as "Patient Pays."
 (804) Benefits have been adjusted based on the non-duplication of benefits provision of the enrollee's program. If this coverage is secondary, the actual payment may be less than the amount estimated.

Claim total for KELVIN HOLMES JR	0.00	0.00	0.00	0.00	0.00		0.00	0.00
----------------------------------	------	------	------	------	------	--	------	------

Notice Requirements for Non-contracted Medicare Providers

Non-contracted providers have the right to request a reconsideration for **denial of payment** within 65 calendar days from the remittance notification date to file the reconsideration. A signed **Waiver of Liability** from holding the member harmless regardless of the outcome of the appeal is required in order to initiate the process of an appeal. Documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical record or other documentation that supports the provider's argument for reimbursement is required. Please submit your reconsideration to Delta Dental at the Administrator address shown on page 1.

Appeals process for Non-contracted Medicare Providers

Your claims statement

Date: July 17, 2025

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination.

SHARP Health Plan link:

<https://www.sharpmedicareadvantage.com/claims-processes-for-non-contracted-medicare-providers>

Other Medicare groups link:

https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip

Delta Dental takes fraud seriously.

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

127979 2/2

