



Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name: JESSICA MULLINS

Business/Dentist: KANSAGRA HARPERS DENTAL GROUP PC INC

Date of Birth: xx/xx/xxxx

License No.: 27530 / OH (NPI: 1558102830)

Relationship: SUBSCRIBER

Check No.: 18085955

Subscriber: JESSICA MULLINS

Issue Date: 06/24/2025

Patient Acct: B06210001641

Receipt Date: 06/17/2025

Claim No.: 2506172833822



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Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Description	Submitted Amount	Maximum Approved Fee	Contract Dentist Savings	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: DELTA DENTAL PLAN OF OHIO						PRODUCT: DELTA DENTAL PPO (POINT-OF-SERVICE)					
CLIENT/ID: 10363 CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER											
SUBCLIENT: 1000 CINCINNATI CHILDRENS MEDICAL CENTER HEALTH AND WELFARE PLAN HIGH											
NETWORK: NONPARTICIPATING DENTIST											
	04/08/25	ORAL EXAM	145.00	145.00		51.00		100%	51.00	94.00	S
	04/08/25	XRAYS	167.00	167.00		94.00		100%	94.00	73.00	S
	04/08/25	IMAGE	404.00	404.00		387.00		80%	309.60	94.40	S
ORIGINALLY SUBMITTED:											
	04/08/25	XRAYS	102.00								
ORIGINALLY SUBMITTED:											
	04/08/25	XRAYS	102.00								
ORIGINALLY SUBMITTED:											
	04/08/25	XRAYS	102.00								
ORIGINALLY SUBMITTED:											
	04/08/25	XRAYS	102.00								
REPLACED BY:											
	04/08/25	XRAYS	408.00	408.00		0.00			0.00	408.00	S
POLICY CODE: EL03400,PP00006											
ORIGINALLY SUBMITTED:											
CONTINUED ON NEXT PAGE											
		Total									



DELTA DENTAL
PO BOX 9085
FARMINGTON HILLS, MI 48333-9085

Important Plan Information



www.deltadentaloh.com
FOR INQUIRIES: 800-524-0149 (TTY users call 711)

000000002809

JESSICA D. MULLINS
4354 GREEN ARBORS LANE
CINCINNATI, OH 45249

Payment for these services is determined in accordance with the specific terms of your dental plan and/or Delta Dental's agreements with its contracting dentists. For inquiries regarding contracting dentists, please call the number listed. Delta Dental's payment decisions do not qualify as dental or medical advice. You must make all decisions about the desirability or necessity of dental procedures and services with your dentist.

If your claim was denied in whole or in part so that you must pay some amount of the claim, upon a written request and free of charge, we will provide you with a copy of any internal rule, guideline or protocol or, if applicable, an explanation of the scientific or clinical judgment relied upon in deciding your claim. If you still believe your claim should have been paid in full, you may ask to have the claim reviewed. Your written request for a formal review must be sent within 180 days of your receipt of this EOB to the address listed. You may submit any additional materials you believe support your claim. A decision will be made no later than 60 days from the date we receive your request, or within a shorter time period if required by law. Failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made. If your claim is denied in whole or in part after the review, you have the right to seek to have your claim paid by filing a civil action in court.

Your privacy is important to us. To access our HIPAA Notice of Privacy Practices or our Gramm-Leach-Bliley Privacy Notice, log onto our website and select the "HIPAA" or "GLB Privacy" link from the home page, or call our Customer Service department to request a written copy.

ANTI-FRAUD TOLL-FREE HOTLINE: (800) 524-0147

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, you can help us lower these costs by calling our toll-free hotline. You do not need to identify yourself. Only ANTI-FRAUD calls can be accepted on this line.

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SUBCLIENT: 1000 CINCINNATI CHILDRENS MEDICAL CENTER HEALTH AND WELFARE PLAN HIGH											
REPLACED BY:	04/08/25	PREVENTIVE	129.00								
POLICY CODE: AP12001,EL00061	04/08/25	TESTS	129.00	129.00		0.00			0.00	129.00	S
THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.											
AP12001 - THE PROCEDURE CODE WAS CHANGED BASED ON THE INFORMATION SUBMITTED OR IN OUR RECORDS.											
EL00061 - THIS PROCEDURE IS NOT A BENEFIT UNDER THE DENTAL PLAN.											
EL03400 - DIAGNOSTIC PHOTOGRAPHS AND CEPHALOMETRIC FILMS, UNLESS DONE FOR COVERED ORTHODONTICS, ARE NOT BENEFITS OF THE DENTAL PLAN.											
PP00006 - THIS FEE IS PART OF THE FEE FOR THE TOTAL PROCEDURE.											
Total			1253.00	1253.00	0.00	532.00	0.00		454.60	798.40	

GENERAL MAXIMUM USED TO DATE: 869.80



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