LIBERTY Dental Plan
PO Box 26110
Santa Ana, CA 92799

PAYMENT DETAILS

VENDOR NAME: **Watanabe and Lynn Professional Dental Corporation** Check Number: PDF
VENDOR NUMBER: 005139 Check Date: 07/22/2025

#	Date Of Service	Code	Tooth #	Surface	Procedure Description	Submitted Amount	Allowed Amount	Co-Pay Amt	Deductible	Co-Ins Amt	Total*	Plan Paid Amount
OFFICE: **Oak Grove Dental Group-PDS, #005139** - Address: 18285 Collier Ave, Ste B, Lake Elsinore, CA 92530-2786												
Patient: **Kang, Jian - 408M92414-01**					**Plan**: Elevance Comprehensive (PA) **Group**: H0544-066 Anthem Select CA							
CLAIM: **64806380 (**Original**)**												
1	07/01/25	D0120			Periodic oral evaluation	95.00	18.70	0.00	0.00	0.00	0.00	0.00
2	07/01/25	D0220			Intraoral, periapical, first radiographic image	62.00	12.10	0.00	0.00	0.00	0.00	0.00
3	07/01/25	D0274			Bitewings, four radiographic images	180.00	30.80	0.00	0.00	0.00	0.00	0.00
4	07/01/25	D0230			Intraoral, periapical, each add 'l radiographic image	175.00	33.00	0.00	0.00	0.00	0.00	0.00
5	07/01/25	D0350			2D oral/facial photographic image, intra-orally/extra-orally	360.00	101.20	0.00	0.00	0.00	0.00	0.00
					CLAIM TOTALS:	872.00	195.80	0.00	0.00	0.00	0.00	0.00

**Amount due from patient*

#	SERVICE LINE EXPLANATION
1	*This claim was processed under the secondary or tertiary coverage. Amount to pay was reduced by $18.70 during COB processing.*
2	*Payment for this service is denied because this same service was already provided. Your plan only allows the service to be paid one time per day per provider office. Please refer to the Member Handbook, Evidence of Coverage (EOC) booklet and/or the clinical criteria for this service. For additional information, you may contact us at LIBERTYDentalPlan.com or call us at 888-703-6999.*
3	*This claim was processed under the secondary or tertiary coverage. Amount to pay was reduced by $30.80 during COB processing.*
4	*This claim was processed under the secondary or tertiary coverage. Amount to pay was reduced by $33.00 during COB processing.*
5	*2D oral/facial photographic image(s) D0350 is only payable on the exam date, when x-rays are not able to be taken or when done as part of orthodontic diagnostic work up and billed with code D8660. No additional payment is available from the plan or from the provider.*

CLAIM: **64806383 (**Original**)**												
1	07/01/25	D4910			Periodontal maintenance	246.00	55.00	0.00	0.00	27.50	0.00	27.50
2	07/01/25	D1330			Oral hygiene instruction	88.00	0.00	0.00	0.00	0.00	0.00	0.00
					CLAIM TOTALS:	334.00	55.00	0.00	0.00	27.50	0.00	27.50

**Amount due from patient*

#	SERVICE LINE EXPLANATION
1	*$27.50 coinsurance was applied for liability 50% Member Coinsurance - Member Responsibility.*
2	*This claim is denied because the service is not covered by the plan. For a list of services that are covered please refer to your Member Handbook or Evidence of Coverage (EOC) booklet. For additional information, you may contact us at LIBERTYDentalPlan.com or call us at 888-703-6999.*

NET PAYMENT FOR PATIENT : 27.50

Patient: **Viramontes, Rogelio - 356W23105-01** **Plan**: Elevance Comprehensive (PA) **Group**: H4161-002 Anthem Prime CA

CLAIM: **64969014 (**Original**)**

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1	07/10/25	D2740	8		Crown, porcelain/ceramic	2,061.00	597.30	0.00	0.00	0.00	0.00	597.30
2	07/10/25	D2950	8		Core buildup, including any pins when required	380.00	100.10	0.00	0.00	0.00	26.50	73.60
3	07/10/25	D2740	9		Crown, porcelain/ceramic	2,061.00	597.30	0.00	0.00	0.00	597.30	0.00
4	07/10/25	D2950	9		Core buildup, including any pins when required	380.00	100.10	0.00	0.00	0.00	100.10	0.00
					CLAIM TOTALS:	4,882.00	1,394.80	0.00	0.00	0.00	723.90	670.90

**Amount due from patient*

#	SERVICE LINE EXPLANATION
2	*The Maximum Allowed For Calendar Year Maximum has been met. Please refer to your Evidence of Coverage (EOC) booklet for additional information or you may contact us by telephone.*
3	*The Maximum Allowed For Calendar Year Maximum has been met. Please refer to your Evidence of Coverage (EOC) booklet for additional information or you may contact us by telephone.*
4	*The Maximum Allowed For Calendar Year Maximum has been met. Please refer to your Evidence of Coverage (EOC) booklet for additional information or you may contact us by telephone.*

NET PAYMENT FOR PATIENT : 670.90

TOTALS PER OFFICE

Original Claims:	698.40
Interest:	0.00
Adjustments:	0.00
GRAND TOTALS PER OFFICE:	**698.40**

VENDOR TOTALS:	6,088.00	1,645.60	0.00	0.00	27.50	723.90	**698.40**

NET PAYMENT : 698.40

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#	Date Of Service	Code	Tooth #	Surface	Procedure Description	Submitted Amount	Allowed Amount	Co-Pay Amt	Deductible	Co-Ins Amt	Total*	Plan Paid Amount

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

HOW DO I FILE AN APPEAL?

CONTRACTED PROVIDER DISPUTE RESOLUTION (PDR)

Contracted providers participating in provider network(s) for Medicare Advantage plans may request an appeal of a denial determination. Appeals must be submitted within 65 days of the date on this remittance advice.

LIBERTY Dental Plan
ATTN: Grievance and Appeals
P.O. Box 26110
Santa Ana, CA 92799-6110
Fax: (833)250-1814
Online: www.libertydentalplan.com

NON-CONTRACTED PROVIDER DISPUTE RESOLUTION (PDR)

Non-contracted providers, pursuant to federal requirements governing the Medicare Advantage program, may request reconsideration of a Medicare Advantage plan denial determination. Requests for reconsideration must be submitted within 65 days of the date of this remittance advice and require a signed waiver of liability (WOL) statement.

Anthem Health Plans, Inc.
ATTN: Grievance and Appeals
4361 Irwin Simpson Road
OH0205-A537
Mason, OH 4504
Fax: (888) 458-1406

SUBMISSION PROCESS (ALL PROVIDERS)

Appeals and requests for reconsideration of a denial determination must be submitted in writing to the appropriate address and within the timeframe identified above, and must include at a minimum: a summary of the appeal or reconsideration request, the member's name, member's identification number, date of service(s), reason(s) why the denial should be reversed and copies of related documentation and/or applicable clinical records to support appropriateness of the services rendered. Requests submitted by non-contracted providers must also include a signed provider Waiver of Liability (WOL) statement form. WOL form website location: **https://www.libertydentalplan.com/Resources/Documents/Model_Waiver_Liability.pdf**

We must give you a decision no later than 30 calendar days after we receive your request.

All other claim inquiries should be sent to:

LIBERTY Dental Plan
P.O. Box 401086

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Las Vegas, NV 89140

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.