Delta Dental Offers Enhanced Explanation of Benefits Statements

Delta Dental's Explanation of Benefits statement is presented in a readable, user-friendly format. Developed in consultation with dentists and members, the form is formatted for ease of reading.

What Delta Dental's Explanation of Benefits Statement Offers

1. **CONTACT INFORMATION**, including a special Customer Service toll-free phone number.

2. **A PAYMENT SUMMARY BOX**, providing at a glance details about charges, payments, deductibles, patient obligations, and Dentist Amount Non Billable (which shows the amount the patient is not billed for).

3. **PATIENT INFORMATION**, including patient’s name, relationship to subscriber, benefit period, group ID and name, and plan type.

4. **CLAIM NUMBER** includes 15 digits.

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**Explanation of Benefits – Dentist Copy**

*See Reverse side if this is not your patient.

**PAYMENT SUMMARY**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Approved Charges</td>
<td>$000.00</td>
</tr>
<tr>
<td>Delta Dental’s Total Payment</td>
<td>$000.00</td>
</tr>
<tr>
<td>Your Other Insurance Paid</td>
<td>$000.00</td>
</tr>
<tr>
<td>Applied to Deductible</td>
<td>$000.00</td>
</tr>
<tr>
<td>Patient Out of Pocket Payment Obligation</td>
<td>$000.00</td>
</tr>
<tr>
<td>Dentist Amount Non Billable</td>
<td>$000.00</td>
</tr>
</tbody>
</table>

**DO NOT SEND PAYMENT TO DELTA DENTAL**

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**MEMBER:**

ROBERT JONES

**RELATIONSHIP:**

SUBSCRIBER

**GROUP ID:**

0000-0000

**GROUP NAME:**

ABC CORPORATION

**PLAN TYPE:**

PREMIER

**CLAIM NUMBER:**

000000000000000

**DATE OF ISSUE:**

00/00/00

**CHECK NUMBER:**

0000000000

**DENTIST ID NUMBER:**

12345NJ

**DENTIST NAME:**

DR. JOHN SMITH

**PAR STATUS:**

PREMIER

**BENEFIT PERIOD:**

00/00/0000 – 00/00/0000

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**TOOTH NO. OR LETTER**

**SURFACE**

**DATE OF SERVICE**

**SUBMITTED SERVICE NO.***

**PAID SERVICE NO.**

**SUBMITTED AMOUNT**

**APPROVED AMOUNT**

**AMT USED FOR BENEFIT CALC**

**DED**

**% COPAY**

**DELTA DENTAL PAYMENT**

**PROCESSING POLICIES**

| XX | XXXXX | 00/00/0000 | 2391 | 2140 | $000.00 | $000.00 | $000.00 | $000.00 | 000 | $000.00 | $000, 000, 000 |

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*PROCEDURE NO. / DESCRIPTION*

2391  Resin based composite – one surface, posterior

2140  Amalgam – one surface, posterior

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NOTICES

Payment was mailed to the subscriber.

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PLEASE SEE REVERSE SIDE OF THIS FORM FOR INFORMATION RELATED TO OUR NOTICE OF PRIVACY PRACTICES, DEFINITIONS, AND OTHER IMPORTANT INFORMATION.
5. **DENTIST INFORMATION**, including the Delta Dental program in which he or she participates for that claim.

6. **MAXIMUM INFORMATION** includes all maximums applicable to the plan the patient is covered under instead of showing plan maximum only.

7. **DETAILED EXPLANATIONS AND DESCRIPTIONS OF INFORMATION IN THE COLUMNS**, including descriptions of each procedure number and explanations, if appropriate, of processing policies (up to 3 per line item allowed). Also features separate ‘Submitted Procedure No.’ and ‘Paid Procedure No.’ to better illustrate when an alternative benefit has been applied.

For questions about specific claims, contact the number for Claims Inquiries on your Explanation of Benefits statement, or e-mail Customer Service at service@deltadentalnj.com.