




Understanding your Explanation of Benefits (EOB)

After a trip to the dentist's office you may receive an Explanation of Benefits (EOB) from Delta Dental explaining the procedures performed and what is covered by your dental plan.

- 1 This section contains subscriber and patient identification information, which you'll need to check on a claims status or to dispute a claim.
- 2 The **Procedure Description** explains the services received at the dentist's office.
- 3 **Submitted Amount** is the amount the dentist charged for the services.
- 4 **Amount Allowed** shows Delta Dental's contracted fees for each procedure.
- 5 If you have a procedure that is not completely covered by Delta Dental, the **Deductible** is the amount applied to the service. You must pay the deductible before Delta Dental will pay the claim.
- 6 **Co-Pay** identifies the percentage the plan will cover per procedure.
- 7 **Payment** is the amount Delta Dental paid your dentist for services rendered.
- 8 **Patient Payment** is the amount the patient owes the dentist. Your dentist should not bill you more than this amount.
- 9 This section includes details about the appeals process.



Explanation of Benefits

(THIS IS NOT A BILL)

1 Patient Name: _____

Date of Birth: _____

Relationship: _____

Subscriber: _____

Business/Dentist: _____

License No: _____

Check No: _____


Issue Date: _____

Receipt Date: _____

Claim No: _____

Pay To: C = Custodial Parent
S = Subscriber
D = 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 Visit	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: DELTA DENTAL CLIENT/ID: 0 SUBCLIENT: 0			2	3		4	5	6	7	8	
NETWORK: PPO DENTIST											
OTHER CARRIER: DELTA DENTAL							OTHER CARRIER PAYMENT AMOUNT: 105.00				
ORIGINALLY SUBMITTED:	10	XX/XX/XX SERVICE	200.00								
REPLACED BY:	10	XX/XX/XX SERVICE	200.00	200.00	0.00	200.00	050.00	70%	95.00	0.00	P
POLICY CODE: XXXXXXX											
Total			200.00	200.00	0.00	200.00	50.00		95.00	0.00	



9 _____

Important Plan Information

*Some EOBs will have additional messages to help patients understand why a procedure wasn't paid.



The Power of Smile™
Learn more about how your oral health connects to your overall health at:
Blog.DeltaDentalNE.org



Delta Dental of Nebraska