



Understand Your Explanation of Benefits (EOB)



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

- A. This section contains subscriber and patient identification information, which you'll need to check on a claims status or to dispute a claim.
- B. The **Procedure Code** and **Procedure Description** explain the services received at the dentist's office.
- C. **Amount Submitted** is the amount the dentist charged for the services.
- D. **Amount Allowed** shows Delta Dental's contracted fees for each procedure.
- E. 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 picks up its share of the tab.
- F. **Co-pay** identifies the percentage the plan will cover per procedure.
- G. **Patient Responsibility** is the amount the patient owes the dentist. Your dentist should not bill you more than this amount.
- H. **Plan Payment** is the amount Delta Dental paid your dentist for services rendered.
- I. This section includes details about the appeals process.

DENTAL BENEFIT PLAN
 P.O. BOX 59238
 MINNEAPOLIS, MN 55459-0238
 MN 651-406-5901 (MINNEAPOLIS/ST. PAUL)
 OR 800-448-3815
 www.deltadentalmn.org

EXPLANATION OF BENEFITS
 THIS IS NOT A BILL

PROVIDER NAME _____
 PROVIDER ID _____
 CLAIM NO. _____

TOOTH NO.	DATE SERVICE COMPLETED	PROCEDURE CODE	PROCEDURE DESCRIPTION	AMOUNT SUBMITTED	AMOUNT ALLOWED	DEDUCTIBLE	CO PAY %	PATIENT RESPONSIBILITY	PLAN PAYMENT	NOTES
		B	B	C	D	E	F	G	H	
CHECK NO. _____			PLAN _____							
ISSUE DATE _____										

FOR CUSTOMER SERVICE REGARDING BENEFIT INFORMATION, ELIGIBILITY OR TO CHECK CLAIMS STATUS PLEASE CALL 651-994-5155 OR 800-587-6857.
 *A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.
 IMPROPER PAYMENTS INCREASE HEALTH CARE COSTS. IF YOU WISH TO REPORT ANY INSTANCE OF SUSPECTED FRAUD, MISUSE, ABUSE OR WASTE OF HEALTH CARE BENEFITS PLEASE CALL THE PROFESSIONAL SERVICES DEPARTMENT. ALL INFORMATION RECEIVED IS CONFIDENTIAL.

I PAYMENT AND PROCESSING POLICIES FOR THESE SERVICES ARE DETERMINED FOR PROPER BENEFITS IN ACCORDANCE WITH THE TERMS OF YOUR DENTAL PLAN AND DO NOT REFLECT ON THE TREATMENT RECOMMENDED BY YOUR DENTIST.

REVIEW AND APPEAL PROCEDURE: YOU MAY REQUEST A REVIEW OF ANY ADVERSE BENEFIT DETERMINATION WITHIN 180 DAYS OF RECEIPT OF THIS STATEMENT. THE APPEAL MUST BE IN WRITING AND INCLUDE YOUR IDENTIFICATION NUMBER.

MAIL TO: APPEALS UNIT
 PO BOX 551
 MINNEAPOLIS, MN 55440-0551

IF YOU HAVE EMPLOYER GROUP COVERAGE SUBJECT TO ERISA, AFTER EXHAUSTION OF ALL APPEALS YOU MAY FILE A CIVIL ACTION UNDER FEDERAL LAW.

*NOTES

Subscriber name _____
 Subscriber ID _____
 Patient Name _____
 Date of Birth _____
 Relationship _____
 Alternate ID _____

A

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

Learn more at:
DeltaDentalMN.org



Delta Dental of Minnesota

DDMN.10.2.18

© 2018 Delta Dental of Minnesota and its affiliates. All rights reserved.
Delta Dental of Minnesota is an authorized licensee of the Delta Dental Plans Association of Oak Brook, Illinois.