



# Understanding Your Explanation of Benefits (EOB)



After a trip to the dentist's office, you may receive an EOB from Delta Dental 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

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.*

## The Power of Smile™

Learn more about how your oral health connects to your overall health at:  
**DeltaDentalMN.org**



Delta Dental of Minnesota