



# How to Read the Delta Dental of Iowa Explanation of Benefits (EOB) Form

- 1** TH The tooth or area that was treated.
- 2** SURF The tooth surface or quadrant that was treated.
- 3** Service Date The date the procedure was completed.
- 4** Proc Code The procedure code that identifies the treatment requested or completed.
- 5** Procedure Description A description of the procedure requested or completed.
- 6** Submit Amt The amount billed by the dentist.
- 7** Fee Adjust The difference, if any, between the Submitted Amount and the Approved Amount. This is the amount participating network dentists shall not bill to the Delta Dental plan member.
- 8** Approved Amt The amount the dentist has agreed to accept as full payment for a service. For participating network dentists, the Approved Amount is the lesser of the Submitted Amount or the applicable maximum plan allowance/negotiated amount.
- 9** Allowed Amt The amount that Delta Dental uses to calculate payment responsibility under the terms of the patient's dental benefits.
- 10** Deduct Applied The deductible is the amount the patient must pay before benefits begin. If the procedure is subject to a deductible, this column will indicate the amount that has been subtracted from the Allowed Amount before calculating Delta Dental's payment and the Patient's Payment.
- 11** Delta Co-Pay The portion of the Allowed Amount Delta Dental will pay, up to the patient's plan maximum.
- 12** Patient Payment The amount the patient is responsible for paying under the terms of the Delta Dental plan benefits. If the procedure is subject to a deductible, the Patient Payment includes the amount from the Deductible Applied column. Except in certain circumstances involving coordination of benefits with another plan, a Delta Dental participating network dentist may only bill the patient for this amount.
- 13** Delta Payment The amount Delta Dental paid.
- 14** Ref Code Explanatory statements applicable to claims processing, benefit coverage and/or processing policy.
- 15** Ded Satisfied The amount the patient has paid to date toward the annual deductible.
- 16** Max Used The amount of the patient's annual maximum coverage limit used to date.
- 17** Ortho Max Used The amount of the lifetime maximum coverage limit for orthodontic benefits used to date.
- 18** Other Carrier Paid The amount paid under the provisions of another group plan when benefits have been coordinated.



DELTA DENTAL OF IOWA  
PO BOX 9000  
JOHNSTON, IA 50131-9000

Forwarding Service Requested

Inquiries: 800-544-0718  
TTY: 888-287-7312  
Date: WWW.DELTADENTALIA.COM

Claim Number:  
Group Name:  
Subscriber:  
Subscriber ID #:  
Patient:  
Patient DOB:  
Dentist:

Other Carrier Paid: **18**

## EXPLANATION OF BENEFITS \*\*THIS IS NOT A BILL\*\*

TH	SURF	Service Date	Proc. Code	Procedure Description	Submit Amt	Fee Adjust	Approved Amt	Allowed Amt	Deduct Applied	Delta Co-Pay	Patient Payment	Delta Payment	Ref. Code
1	2	3	4	5	6	7	8	9	10	11	12	13	14
TOTALS													
					Check Number	Check Amount	For Benefit Year	Ded. Satisfied	Max Used	Ortho Max Used			
					43	45	46	47					

### Reference Codes

PAYMENT FOR THESE SERVICES IS DETERMINED IN ACCORDANCE WITH THE SPECIFIC TERMS OF YOUR DENTAL PLAN AND WITH THE TERMS OF THE AGREEMENTS WITH NETWORK DENTISTS. PROCEDURES REQUIRING PROFESSIONAL JUDGEMENT FOR BENEFIT DETERMINATION HAVE BEEN REVIEWED BY A DENTAL CONSULTANT.

\*\*\* At Delta Dental of Iowa, we are passionate about oral health and its importance to generations of families. For over 50 years, we have worked to improve oral health by emphasizing preventative care and making dental coverage accessible to a wide variety of employers, groups and individuals. Visit the subscriber connection at [www.DeltaDentalia.com](http://www.DeltaDentalia.com) for secure, personalized information on eligibility, claims history and claims status for you and your dependents.

### RIGHTS OF REVIEW AND APPEAL

If you have question regarding your claim, please contact Delta Dental of Iowa at 1-800-544-0718. If you disagree with the denial, or partial denial of a claim, you or your representative are entitled to a full and fair review of the claim. To file for a review: Submit a request within 180 days of receiving this notice, including the reason why you disagree with our claim decision, documents, records and any other information related to the claim. Include the subscriber's identification number on all documents.

Upon your request, we will provide you, free of charge, access to and copies of all documents, records and other information relevant to your claim for benefits. Within 30 days of receiving your request we will send you our written decision and indicate any action we have taken. (Special circumstances may require 60 days)

Send your requests to: Delta Dental of Iowa, P.O. Box 9000, Johnston, IA 50131-9000 or call 1-800-544-0718.