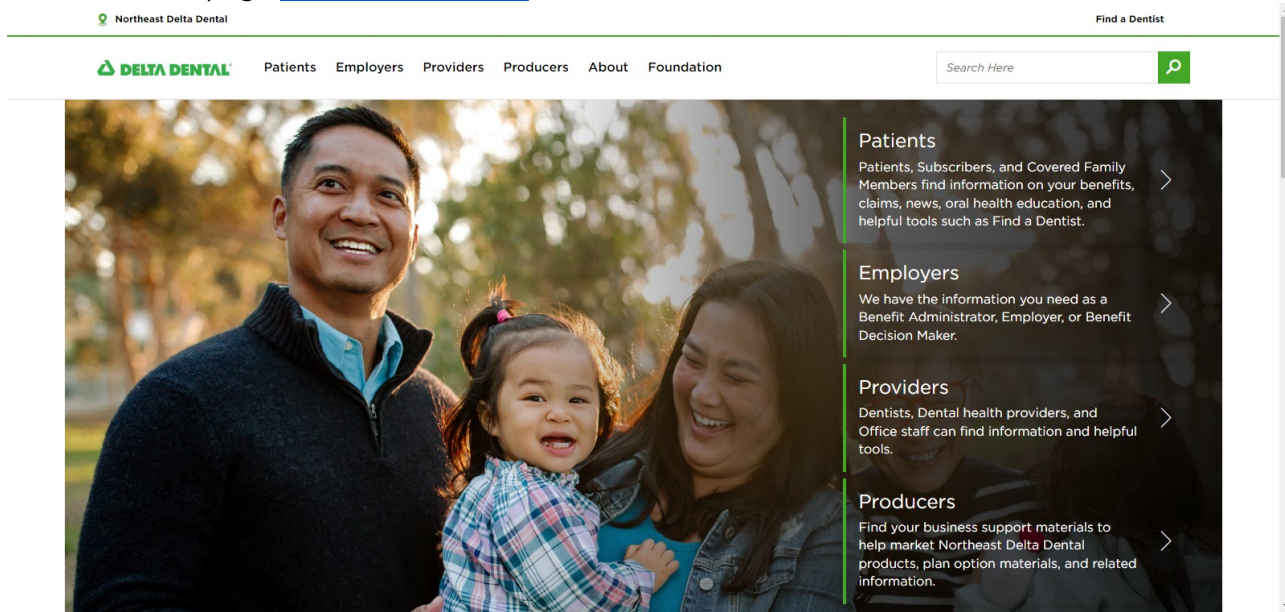


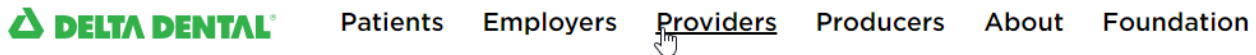
# Navigating Northeast Delta Dental's My Benefit Web Page for Providers

Follow these instructions to obtain patient eligibility and benefit information.

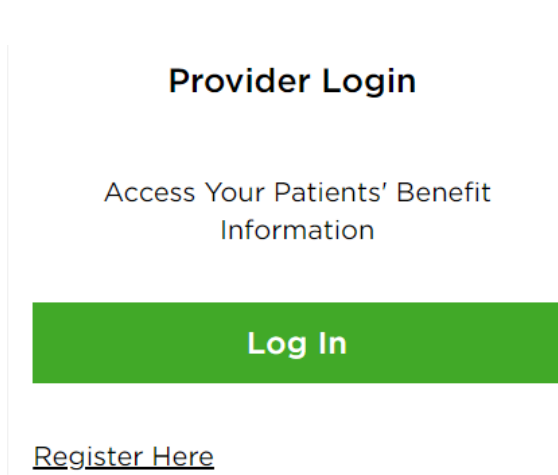
Go to our web page [www.NEDelta.com](http://www.NEDelta.com)



Select Providers at the top of the page.



Select the green LOG In button to access the Providers page.



To view MAC, PPO Schedule, or Non Participating fees, select the Fee Schedules in the green ribbon.



Select dentist Location, Network of fees, Date of Service and select Lookup.

**DELTA DENTAL** Northeast Delta Dental

Home Fee Schedules Contact Us Log Out Print Current Page

Provider Name:  Provider State:  Provider TIN:  Provider License:

Location  Network  Date of Service  Lookup Reset

Code	Description	Fee

© 2022 - Benefit Lookup [Privacy Policy](#)

*Note: A calendar for June 2022 is shown with the 14th highlighted. A dropdown menu for Network shows options: Premier, PPO, Non Participating Fees, State of Maine Employees.*

Subscriber Lookup:

Enter the subscriber ID number in the search by Subscriber ID Number or search by First Name, Last Name, Date of Birth, and Select Lookup.

Home Fee Schedules Contact Us Log Out Print Current Page

**IMPORTANT REMINDER:** To ensure proper claims payment, please contact the Provider Services department at 1-800-537-1715 ext 1100 before making any dentist and/or office changes or updates. For a list of examples click [here](#).

Provider Name:   
Provider State:   
Provider TIN:   
Provider License:

**HOW HEALTH through ORAL WELLNESS** [Click Here to Register for HOW](#)®

**EFT ERA** Northeast Delta Dental offers Electronic Funds Transfers (EFT) and Electronic Remittance Advice (ERA). Click [here](#) to learn more and sign up today!

Click here to [Access Delta Dental ERAs on DentalXChange](#)  
Click here to [Access Delta Dental ERAs on Change Healthcare](#)

**View Subscriber Eligibility**

In Tri-state Lookup  Out of Tri-state Lookup ?

Search by Subscriber ID Number:

**OR**

Search by First Name:  Last Name:  Date of Birth:  ? Lookup

See active subscriber benefit information.



Northeast Delta Dental

[Nondiscrimination in Healthcare Grievance Procedure](#)

Home Fee Schedules Contact Us Log Out Print Current Page

*Information displayed on this website is based on current available benefits and patients' eligibility. It is possible this information may change, even retroactively, based on information provided by the account. Should changes occur in eligibility or benefits, there is no guarantee of payment.*

**Northeast Delta Dental**

**Subscriber:** [Redacted]  
**Address:** [Redacted]  
**Product:** Delta Dental PPO<sup>SM</sup>  
**Group Number:** [Redacted]  
**Group Name:** DELTA DENTAL PLAN OF NEW HAMPSHIRE

**Customer Service:** 1-800-832-5700

**Subscriber ID:** [Redacted]  
**Dependent Age Limit:** 26  
**Student Age Limit:** 26  
**Ortho Age Limit:** 99  
**Today's Date:** 6/14/2022 2:49:43 PM

- For coordination of benefits contact Customer Service
- To maximize your coverage, please bill any service(s) covered by the medical plan to that carrier.
- The date of incurred liability for multiple visit procedures is the completion date.
- This group participates in the Health through Oral Wellness (HOW) program.

Name	Relationship	Birthdate	Effective Date	Termination Date
<a href="#">Select</a>	<b>Subscriber</b>	[Redacted]	03/01/2017	<b>Active</b>
<a href="#">Select</a>	Spouse/Partner	[Redacted]	03/01/2017	Active

- Individual available carryover: \$1898.52
- This individual has additional benefits for both CRIES and for PERIO through the Health through Oral Wellness program, which includes the caries susceptibility test (D0425) once per 12 month period; prophylaxis (D1120, D1110, D4346, D4910) combination up to 4 per 12 month period or per calendar year; and Full Mouth Debridement (D4355) once per lifetime, which counts toward the frequency for cleanings. Fluoride treatments (D1206/D1208) with no age restrictions-combination up to 4 per 12 month period or per calendar year; Sealants with no age restrictions (D1351) 1 in a 3 year period for unrestored primary molars and for unrestored permanent bicuspids and molars; and either one Nutritional Counseling (D1310) or Tobacco Cessation Counseling (D1320) or Oral Hygiene Instruction (D1330) is covered in a 12 month period.

You will have access claims and Explanation of Benefits (EOB's) for your terminated patients.



Northeast Delta Dental

[Nondiscrimination in Healthcare Grievance Procedure](#)

Home Fee Schedules Contact Us Log Out Print Current Page

*Information displayed on this website is based on current available benefits and patients' eligibility. It is possible this information may change, even retroactively, based on information provided by the account. Should changes occur in eligibility or benefits, there is no guarantee of payment.*

**Northeast Delta Dental**

**Subscriber:** [Redacted]  
**Address:** [Redacted]  
**Product:** Delta Dental PPO plus Premier  
**Group Number:** 000003130-00002002-0000  
**Group Name:** UNION LEADER CORPORATION

**Customer Service:** 1-800-832-5700

**Subscriber ID:** [Redacted]  
**Dependent Age Limit:** 25  
**Student Age Limit:** 25  
**Ortho Age Limit:** 19  
**Today's Date:** 3/1/2021 10:03:02 AM

Name	Relationship	Birthdate	Effective Date	Termination Date
<a href="#">Select</a>	<b>Subscriber</b>	[Redacted]	07/01/2015	05/31/2020
<a href="#">Select</a>	Spouse/Partner	[Redacted]	[Redacted]	[Redacted]
<a href="#">Select</a>	Dependent	[Redacted]	[Redacted]	[Redacted]
<a href="#">Select</a>	Dependent	[Redacted]	[Redacted]	[Redacted]

**Claims by Individual (based on individual selected above)**

View	Claim #	Date of Service	Patient	Status	Dentist Name
<a href="#">View</a>	2019	06-12-2019	[Redacted]	Processed	[Redacted]

Select View to get Explanation of Benefits

[← Previous Year](#) [Current Year](#) [Next Year →](#)

General Claim Information												
Claim Number: [Redacted]			Patient Name: [Redacted]			Provider Name: [Redacted]			Patient DOB: [Redacted]			
Subscriber ID: [Redacted]			Subscriber Name: [Redacted]			Delta Payment: \$183.00			Patient Responsibility: \$ 00			
Coordination of Benefits: \$ 00			Deductible: \$ 00			Claim Received: 06-13-2019			Check Number: [Redacted]			
Claim Status: Processed			Paid Date: 06-14-2019			Paid To: Provider						
Tooth No.	Date of Service	Proc.No.	Procedure Description	Amount Submitted	Amount Approved	Amount Allowed	Applied to Deduct	Plan Co-Pay %	OV Co-Pay	Patient Payment	Plan Payment	Processing Policy
	06-12-2019	D1110	Prophy/laxis-adult	\$85.00	\$85.00	\$85.00	\$ 00	100	0	\$ 00	\$85.00	
	06-12-2019	D0120	Periodic oral eval	\$40.00	\$40.00	\$40.00	\$ 00	100	0	\$ 00	\$40.00	
	06-12-2019	D0274	Bitewings-four images	\$60.00	\$58.00	\$58.00	\$ 00	100	0	\$ 00	\$58.00	

[Print EOB](#)

**DELTA DENTAL**

**EXPLANATION OF BENEFITS (EOB)**  
THIS IS NOT A BILL. PAYABLE BENEFITS HAVE BEEN ISSUED TO THE PROVIDER LISTED BELOW.

Subscriber: [Redacted]  
Subscriber ID Number: [Redacted] Date Paid: 06/14/2022

**NORTHEAST DELTA DENTAL**  
Customer Service  
ONE DELTA DR. P.O. BOX 2002  
CONCORD, NH 03302-2002  
(603) 223-1234  
E-MAIL: NEDENTAL@DELTA.COM  
TTY: 711  
www.nedelta.com

TOTAL FEE SUBMITTED	\$ 1318.00
TOTAL PATIENT PAYMENT TO PROVIDER	\$ 0.00
TOTAL PLAN PAYMENT	\$ 1318.00

Delta Dental Program for Group Number: [Redacted]

**NOTICES**  
IF YOUR CLAIM HAS BEEN DENIED IN WHOLE OR IN PART, YOU MAY REQUEST A REVIEW OF THE CLAIM DECISION WITHIN 90 DAYS (6 MONTHS OF THE DATE OF THIS EXPLANATION OF BENEFITS) YOUR RIGHT TO REVIEW INCLUDES THE RIGHT TO A SECOND PROFESSIONAL OPINION. NORTHEAST DELTA DENTAL, ONE DELTA DRIVE, P.O. BOX 2002, CONCORD, NH 03302-2002. IF ANY PART OF THE CLAIM REMAINS DENIED AFTER THE CLAIM REVIEW, YOU MAY APPEAL TO THE DISPUTED CLAIMS REVIEW COMMITTEE BY THE DATE SPECIFIED IN THE REVIEW NOTICE. DISCUSS LETTERS OR RECORDS BE GIVEN WITHIN 90 DAYS OF THE NOTICE. YOUR APPEAL SHOULD BE MAILED TO THE VICE PRESIDENT, PROFESSIONAL RELATIONS AT THE ADDRESS GIVEN ABOVE. YOU MAY ALSO BRING SUIT UNDER SECTION 2518A OF THE RSA. PLEASE REFER TO YOUR DENTAL PLAN DESCRIPTION FOR FULL DETAILS OF YOUR COVERAGE AND DISPUTED CLAIMS PROCEDURES.

CLAIM NUMBER	PATIENT NAME	DATE OF BIRTH	PROVIDER NAME								
TOOTH NO.	DATE OF SERVICE	PROC. DESCRIPTION OF SERVICE	SUBMIT	APPR	ALLOW	DED PLAN %	COVP	PT PAY	PLAN PAYMENT	CFR1	PROCESSING POLICY
06-13-2019	0115	Prophylaxis adult	\$88.00	\$88.00	\$88.00	\$0.00	100	0	\$0.00	\$88.00	\$1.00
06-13-2019	0208	Periodic oral exam	\$48.00	\$48.00	\$48.00	\$0.00	100	0	\$0.00	\$48.00	\$0.00
06-12-2019	02074	30-day x-ray images	\$88.00	\$88.00	\$88.00	\$0.00	100	0	\$0.00	\$88.00	\$2.00

\*ACTUAL FEE REDUCTION

If the subscriber is terminated, and they were not one of your patients, a red message will state the subscriber was terminated and ask you to call Customer Service for information.

**View Subscriber Eligibility**

[Click here to View Delta Dental ERAs](#) ⓘ

In Tri-state Lookup  Out of Tri-state Lookup ⓘ

**The subscriber you are requesting has been terminated on 12/31/2002. Please refer to the subscriber's Delta Dental card or contact Customer Service at 1-800-832-5700 for further information.**

Search by Subscriber ID Number:

If the subscriber you entered is invalid, a red message will confirm this and ask you to call Customer Service.

**Subscriber ID entered is invalid. Please refer to the subscriber's Delta Dental card or contact Customer Service at 1-800-832-5700 for further information.**

Special messages are noted in the box below the Group Name.

**DELTA DENTAL** Northeast Delta Dental [Nondiscrimination in Healthcare Grievance Procedure](#)

Home Fee Schedules Contact Us Log Out [Print Current Page](#)

*Information displayed on this website is based on current available benefits and patients' eligibility. It is possible this information may change, even retroactively, based on information provided by the account. Should changes occur in eligibility or benefits, there is no guarantee of payment.*

**Northeast Delta Dental**  
 Subscriber: [Redacted] Customer Service: 1-800-832-5700  
 Address: [Redacted] Subscriber ID: [Redacted]  
 Product: Delta Dental PPO<sup>SM</sup> Dependent Age Limit: 26  
 Group Number: [Redacted] Student Age Limit: 26  
 Group Name: DELTA DENTAL PLAN OF NEW HAMPSHIRE Ortho Age Limit: 99  
 Today's Date: 6/14/2022 2:49:43 PM

- For coordination of benefits contact Customer Service
- To maximize your coverage, please bill any service(s) covered by the medical plan to that carrier.
- The date of incurred liability for multiple visit procedures is the completion date.
- This group participates in the Health through Oral Wellness (HOW) program.

Individual available carryover benefit displays.

Name
Select [Redacted]
• Individual available carryover: \$250.00

Individual HOW benefits display per qualification. Example below reflects Caries and Periodontal additional HOW benefits.

Name	Relationship	Birthday	Effective Date	Termination Date
<a href="#">Select</a>	Subscriber		09/01/2017	Active

- Individual available carryover: \$250.00
- This individual has additional benefits for both CARIES and for PERIO through the Health through Oral Wellness program, which includes the caries susceptibility test (D0425) once per 12 month period; prophy codes (D1120, D1110, D4346, D4910) combination up to 4 per 12 month period or per calendar year; and Full Mouth Debridement (D4355) once per lifetime, which counts toward the frequency for cleanings. Fluoride treatments (D1206/D1208) with no age restrictions-combination up to 4 per 12 month period or per calendar year; Sealants with no age restrictions (D1351) for unrestored primary molars and for unrestored permanent bicuspid and molars; and either one Nutritional Counseling (D1310) or Tobacco Cessation Counseling (D1320) or Oral Hygiene Instruction (D1330) is covered in a 12 month period.

### Periodontal additional HOW benefits

• This individual has additional benefits for PERIO through the Health through Oral Wellness program, which includes the prophy codes (D1120, D1110, D4346, D4910) combination up to 4 per 12 month period or per calendar year; one Nutritional Counseling (D1310) or Tobacco Cessation Counseling (D1320) or Oral Hygiene Instruction (D1330) in a 12 month period; and Full Mouth Debridement (D4355) once per lifetime, which counts toward the frequency for cleanings.

### Caries additional HOW benefits

• This individual has additional benefits for CARIES through the Health through Oral Wellness program, which includes the caries susceptibility test (D0425) once per 12 month period; prophy codes (D1120, D1110, D4346, D4910) combination up to 4 per 12 month period or per calendar year; and Full Mouth Debridement (D4355) once per lifetime, which counts toward the frequency for cleanings. Fluoride treatments (D1206/D1208) with no age restrictions-combination up to 4 per 12 month period or per calendar year; Sealants with no age restrictions (D1351) for unrestored primary molars and for unrestored permanent bicuspid and molars; and either one Nutritional Counseling (D1310) or Oral Hygiene Instruction (D1330) is covered in a 12 month period.

### Benefits

<b>Benefit Levels</b>	<b>Maximums &amp; Deductibles</b>	<b>Limitations</b>	<b>Claims</b>	<b>Pretreatment Estimate</b>
-----------------------	-----------------------------------	--------------------	---------------	------------------------------

[Hide/Show ADA Procedure Codes](#)

Benefits are listed by ADA Service Type.

Service Type
<a href="#">Adjunctive Dental Services</a> D9110, D9310, D9941, D9999
<a href="#">Anesthesia</a> D9222, D9223, D9239, D9243
<a href="#">Dental Prophylaxis</a> D1110, D1120, D4346, D4355

Waiting Period will either display number of Months, MET or NONE.

<b>Waiting Period</b> 6 MONTHS	<b>Waiting Period</b> MET	<b>Waiting Period</b> NONE
-----------------------------------	------------------------------	-------------------------------

Patient Pays Percent:

The plan benefit reflects the patient's responsibility per provider network. Patients pay a percent of the Out of Network fee table and not what the provider bills the patient.

Delta Dental PPO		Delta Dental Premier		Out of Network	
Patient Pays	Deductible Applies	Patient Pays	Deductible Applies	Patient Pays	Deductible Applies
20%	NO	20%	NO	20%	NO
20%	NO	20%	NO	20%	NO
20%	NO	20%	NO	20%	NO
20%	NO	20%	NO	20%	NO
50%	NO	50%	NO	50%	NO

\*Patients who visit an out of network provider may pay up to 100% of the total amount charged by the provider.

Procedure Exceptions include procedure codes with different waiting periods or patient pay percentage.

Procedure Exceptions	Waiting Period	Delta Dental PPO	
		Patient Pays	Deductible Applies
D0425 - Caries suspect test	NONE	0%	NO
D0484 - Consultation on slides	NONE	0%	NO
D1310 - Nutritional counseling	NONE	0%	NO
D1320 - Tobacco counseling	NONE	0%	NO
D1330 - Oral hygiene instruction	NONE	0%	NO
D1550 - Recem space maintainer	NONE	0%	NO
D2391 - Resin based comp 1 surf	NONE	0%	NO

Maximums and Deductibles:

Benefit balances based on product type and dentist network participation.

Benefit Levels	Maximums & Deductibles	Limitations	Claims	Pretreatment Estimate
Benefit Period: 01/01/2017 - 12/31/2017				
<b>Benefit Balances :</b>				
<b>Delta Dental PPO</b>				
Individual: All Covered Classes (Excluding Ortho)	\$1600.00 per year, \$755.80 remaining			
Individual: Orthodontics	\$1500.00 lifetime, \$1500.00 remaining			
<b>Delta Dental Premier</b>				
Individual: All Covered Classes (Excluding Ortho)	\$1600.00 per year, \$755.80 remaining			
Individual: Orthodontics	\$1500.00 lifetime, \$1500.00 remaining			
<b>Out of Network</b>				
Individual: All Covered Classes (Excluding Ortho)	\$1600.00 per year, \$755.80 remaining			
Individual: Orthodontics	\$1500.00 lifetime, \$1500.00 remaining			
<b>Deductibles :</b>				
<b>Delta Dental PPO</b>				
Individual: All Covered Classes (Excluding Diagnostic & Preventive and Ortho)	\$50.00 per year, \$0.00 remaining			
Family: All Covered Classes (Excluding Diagnostic & Preventive and Ortho)	\$100.00 per year, \$0.00 remaining			
<b>Delta Dental Premier</b>				
Individual: All Covered Classes (Excluding Diagnostic & Preventive and Ortho)	\$50.00 per year, \$0.00 remaining			
Family: All Covered Classes (Excluding Diagnostic & Preventive and Ortho)	\$100.00 per year, \$0.00 remaining			
<b>Out of Network</b>				
Individual: All Covered Classes (Excluding Diagnostic & Preventive and Ortho)	\$50.00 per year, \$0.00 remaining			
Family: All Covered Classes (Excluding Diagnostic & Preventive and Ortho)	\$100.00 per year, \$0.00 remaining			



Limitations:

Select this tab to view covered procedures, time frequency, and the Procedure Search feature.

[Benefit Levels](#)
[Maximums & Deductibles](#)
[Limitations](#)
[Claims](#)
[Pretreatment Estimate](#)

**Procedure Search:** D  - Tth # (optional):   [Tooth Chart](#)

The Procedure Search feature shows the benefits and recent treatment dates for the procedure code entered.

Enter a valid procedure code in the box following the "D" and refine your search by adding a tooth number in the box following the Tth# (optional), and select Search button.

Example:

**Procedure Search:** D  - Tth # (optional):   [Tooth Chart](#)

<p><b>Limitations information:</b></p> <p><b>Procedure:</b> D1110 (Prophylaxis-adult)  <b>Time Limitation:</b> 2 in a 12 month period  <b>Age Limit Low:</b> 0  <b>Age Limit High:</b> 0  <b>Procedure Grouping:</b> D1110, D1120, D4346, D4355, D4910</p>	<p><b>Recent Treatments (last 4):</b></p> <p>06/22/2017 (D1110)  09/08/2016 (D1110)  02/05/2015 (D1110)  07/24/2014 (D1110)</p>
--	---

**Procedure Search:** D  - Tth # (optional):   [Tooth Chart](#)

<p><b>Limitations information:</b></p> <p><b>Procedure:</b> D2391 (Resin based comp 1 surf)  <b>Time Limitation:</b> 1 in a 24 month period  <b>Age Limit Low:</b> 0  <b>Age Limit High:</b> 0  <b>Procedure Grouping:</b> D2391, D2392, D2393, D2394</p>	<p><b>Recent Treatments (last 4):</b></p> <p>10/20/2016 (D2391) - Tth: 31 Surface(s): L  09/08/2016 (D2391) - Tth: 31 Surface(s): B  08/07/2014 (D2393) - Tth: 31 Surface(s): MOL  08/07/2014 (D2392) - Tth: 29 Surface(s): DO</p>
---	--

Please note you cannot search by tooth number alone. If code is not covered, it will return as a non covered service.

**Procedure Search:** D  - Tth # (optional):   [Tooth Chart](#)  
**1352 is a non covered service**

Service Type displays Frequencies and Limitations.

\* Select underlined service type to see covered ADA procedure codes.

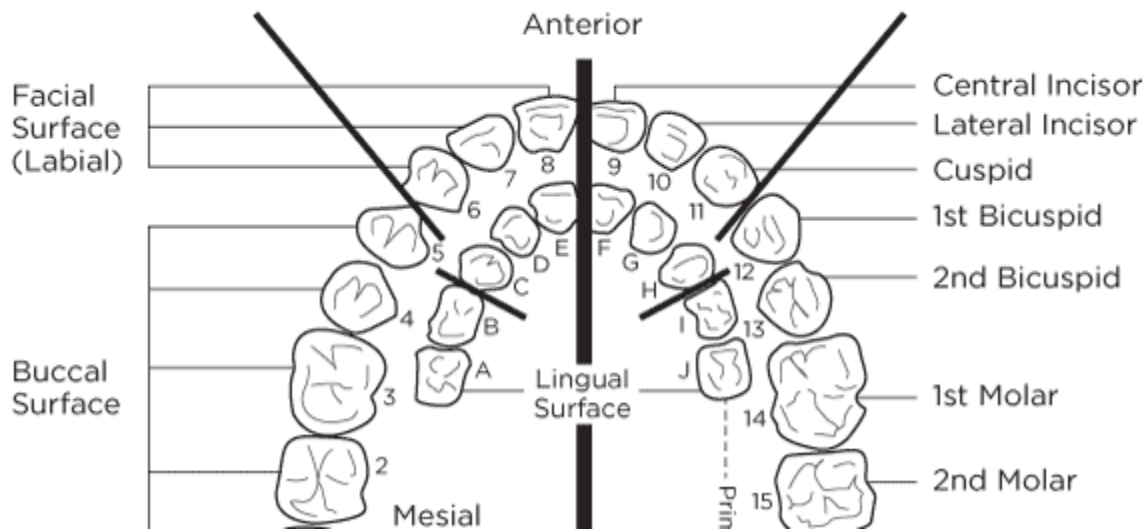
Service Type	Frequencies	Limitations
<u>Dental Crowns</u>	1 in a 7 year period	Procedure level tooth limits apply
<u>Dental Implants</u>	1 in a lifetime	Procedure level tooth limits apply
<u>Dental Prophylaxis</u>	4 in 1 calendar year	Prophylaxis, Periodontal Maintenance or Full Mouth Debridement
<u>Diagnostic Lab</u>	1 in a 12 month period	

Procedure Exceptions display the codes that vary by Frequencies and Limitations.

Procedure Exceptions	Frequencies	Limitations
D0425 - Caries suscept test	1 in a 12 month period	
D1310 - Nutritional counseling	1 in a 12 month period	
D1320 - Tobacco counseling	1 in a 12 month period	
D1330 - Oral hygiene instruction	1 in a 12 month period	
D2910 - Recem partial cov rest	1 in a lifetime	Tooth/Quadrant/Arch limits apply

Select the underlined Tooth Chart for your reference.

- Tth # (optional):  Search [Tooth Chart](#) close



Claims:

Select the Claims tab to view claim details.

[Claims by Individual](#) (based on individual selected above)

Please note that the dentist can view patient claims submitted by them and not claims sent by other providers.

Choose Select next to the Name of the covered member who you want to view claim information.

Name
<a href="#">Select</a>
<a href="#">Select</a>



Select View to see entire claim.

Benefit Levels   Maximums & Deductibles   Limitations   **Claims**   Pretreatment Estimate


**Claims by Individual** (based on individual selected above)

	Claim #	Date of Service	Patient	Status	Dentist Name
<a href="#">View</a>	20170	01-04-2017		Processed	
<a href="#">View</a>	2017.	04-04-2017		Processed	
<a href="#">View</a>	2017	06-28-2017		Processed	

[◀ Previous Year](#)   [Current Year](#)   [Next Year ▶](#)

**Claim Status Report**

Benefits described in this document are not a guarantee of payment. Specific information regarding general exclusions and limitations to include waiting periods are noted in the Dental Plan Description booklet. We mail Notification of Benefits to our subscribers and participating dentists. If you have any questions, please email our Customer Service Department at nedelta@nedelta.com or call our Customer Service Department at 1-800-832-5700 Monday through Friday from 8:00am to 4:45pm (ET).

Please click on the processing policy number/text icon  when available below to view additional information related to the procedure performed.

Please click on the yellow column headings to view a more detailed description.

**General Claim Information**

Claim Number:	20171050000101	Patient Name:	
Provider Name:		Patient DOB:	
Subscriber ID:		Subscriber Name:	
Delta Payment:	\$546.00	Patient Responsibility	\$234.00
Coordination of Benefits:	\$0.00	Deductible:	\$0.00

<u>Claim Received</u>	<u>Claim Status</u>
06-14-2017	Pre-Determination

**Treatment Information**

Tooth No.	Date of Service	Proc.No.	Procedure Description	Amount Submitted	Amount Approved	Amount Allowed	Applied to Deduct	Plan Co-Pay %	OV Co-Pay	Patient Payment	Plan Payment
31	06-14-2017	D2950	Core buildup	\$160.00	\$130.00	\$130.00	\$0.00	70	0	\$39.00	\$91.00
31	06-14-2017	D2740	Crown-porc/ceramic	\$750.00	\$650.00	\$650.00	\$0.00	70	0	\$195.00	\$455.00

Pretreatment Estimate:


Select the Pretreatment Estimate tab to view estimates. Select View to see entire estimate.

Benefit Levels   Maximums & Deductibles   Limitations   Claims   **Pretreatment Estimate**

**Claims by Individual** (based on individual selected above)

	Claim #	Date of Service	Patient	Status	Dentist Name
<a href="#">View</a>				Pre-Determination	

[◀ Previous Year](#)   [Current Year](#)   [Next Year ▶](#)

Benefit Levels	Maximums & Deductibles	Limitations	Claims	Pretreatment Estimate							
Claims by Individual (based on individual selected above)											
Claim #	Date of Service	Patient	Status	Dentist Name							
<a href="#">View</a> 2017			Pre-Determination								
<a href="#">View</a> 2017			Pre-Determination								
<a href="#">View</a> 2017			Pre-Determination								
<a href="#">← Previous Year</a> <a href="#">Current Year</a> <a href="#">Next Year →</a>											
Claim Status Report											
Benefits described in this document are not a guarantee of payment. Specific information regarding general exclusions and limitations to include waiting periods are noted in the Dental Plan Description booklet. We mail Notification of Benefits to our subscribers and participating dentists. If you have any questions, please email our Customer Service Department at nedelta@nedelta.com or call our Customer Service Department at 1-800-832-5700 Monday through Friday from 8:00am to 4:45pm (ET).											
Please click on the processing policy number/text icon  when available below to view additional information related to the procedure performed.											
Please click on the yellow column headings to view a more detailed description.											
General Claim Information											
Claim Number:		Patient Name:									
Provider Name:		Patient DOB:									
Subscriber ID:		Subscriber Name:									
Delta Payment:	\$1,039.20	Patient Responsibility:	\$508.80								
Coordination of Benefits:	\$ .00	Deductible:	\$ .00								
Claim Received		Claim Status									
Treatment Information											
Tooth No.	Date of Service	Proc.No.	Procedure Description	Amount Submitted	Amount Approved	Amount Allowed	Applied to Deduct	Plan Co-Pay %	OV Co-Pay	Patient Payment	Plan Payment
19		D2750	Crown-porc/high noble	\$1,497.00	\$1,248.00	\$1,044.00	\$ .00	80	0	\$412.80	\$835.20
19		D2950	Core buildup	\$338.00	\$300.00	\$255.00	\$ .00	80	0	\$96.00	\$204.00

Please note that the dentist can view patient Pretreatment Estimates submitted by them and not by other providers.

### Explanation of Benefits (EOB)

General Claim Information												
Claim Number:		Patient Name:										
Provider Name:		Patient DOB:										
Subscriber ID:		Subscriber Name:										
Delta Payment:	\$70.00	Patient Responsibility:	\$14.00									
Coordination of Benefits:	\$ .00	Deductible:	\$ .00									
<u>Claim Received</u>	<u>Claim Status</u>	<u>Paid Date</u>	<u>Paid To</u>	<u>Check Number</u>								
07-03-2017	Processed	07-05-2017	Provider	8410204								
Treatment Information												
Tooth No.	Date of Service	Proc.No.	Procedure Description	Amount Submitted	Amount Approved	Amount Allowed	Applied to Deduct	Plan Co-Pay %	OV Co-Pay	Patient Payment	Plan Payment	Processing Policy
	06-30-2017	D0140	Ltd oral eval prob focus	\$104.00	\$84.00	\$70.00	\$ .00	100	0	\$14.00	\$70.00	
<a href="#">Print EOB</a>												

Select Print EOB button to view the EOB.



Northeast Delta Dental  
 PO Box 2002  
 Concord, NH 03302-2002

**EXPLANATION OF BENEFITS  
 (EOB)**  
**THIS IS NOT A BILL**  
 PAYABLE BENEFITS HAVE BEEN ISSUED TO THE  
 PROVIDER LISTED BELOW

Subscriber [Redacted]  
 Subscriber ID Number [Redacted]

Date Paid 07-05-2017

**NORTHEAST DELTA DENTAL**

Customer Service  
 ONE DELTA DR. P.O. BOX 2002  
 CONCORD, NH 03302-2002  
 (800) 832-5700  
 (603) 223-1234  
 E-MAIL: NEDELTA@NEDELTA.COM  
 TTY: (800) 332-5905  
 www.nedelta.com

TOTAL FEE SUBMITTED	\$	\$104.00
	\$	
	\$	
TOTAL PATIENT PAYMENT TO PROVIDER	\$	\$14.00
TOTAL PLAN PAYMENT	\$	\$70.00

Dental Benefit Program for Group Number  
 Group: [Redacted] Sublocation: 0004196 Division: 0000

**NOTICES**

IF YOUR CLAIM HAS BEEN DENIED IN WHOLE OR IN PART, YOU MAY REQUEST A REVIEW OF THE CLAIM DECISION WITHIN SIX (6) MONTHS OF THE DATE OF THIS EXPLANATION OF BENEFITS. YOUR REQUEST FOR REVIEW SHOULD BE SENT TO: VICE PRESIDENT, PROFESSIONAL RELATIONS, NORTHEAST DELTA DENTAL, ONE DELTA DRIVE, P.O. BOX 2002, CONCORD, NH 03302-2002. IF ANY PART OF THE CLAIM REMAINS DENIED AFTER THE CLAIM REVIEW, YOU MAY APPEAL TO THE DISPUTED CLAIMS REVIEW COMMITTEE BY THE DATE SPECIFIED IN THE INITIAL REVIEW DECISION LETTER OR, IF NO DATE IS GIVEN, WITHIN SIX (6) MONTHS OF THE NOTICE. YOUR APPEAL SHOULD BE MAILED TO THE VICE PRESIDENT, PROFESSIONAL RELATIONS AT THE ADDRESS GIVEN ABOVE. YOU MAY ALSO BRING SUIT UNDER SECTION 502(A) OF ERISA. PLEASE REFER TO YOUR DENTAL PLAN DESCRIPTION FOR FULL DETAILS OF YOUR COVERAGE AND DISPUTED CLAIMS PROCEDURES.

**CLAIM INFORMATION**

CLAIM NUMBER:		PATIENT NAME:		DATE OF BIRTH:		PROVIDER NAME:							
[Redacted]		[Redacted]		[Redacted]		[Redacted]							
TOOTH NO.	DATE OF SERVICE	PROC. NO.	DESCRIPTION OF SERVICE	SUBMIT	APPR	ALLOW	DED	PLAN %	OVCP	PT PAY	PLAN PAYMENT	CFR*	PROCESSING POLICY
	06-30-2017	D0140	Ltd oral eval prob focus	\$104.00	\$84.00	\$70.00	\$0.00	100	0	\$14.00	\$70.00	\$20.00	

\*CONTRACTUAL FEE REDUCTION

**Processing Policies**

PAYMENT / PREDETERMINATION OF PAYMENT OF THESE SERVICES IS DETERMINED IN ACCORDANCE WITH THE SPECIFIC TERMS OF THE SUBSCRIBER'S DENTAL PLAN OR WITH THE TERMS OF DELTA DENTAL'S AGREEMENTS WITH DELTA DENTAL NETWORK DENTISTS. PROCEDURES REQUIRING PROFESSIONAL JUDGMENT FOR BENEFIT DETERMINATION HAVE BEEN REVIEWED BY A DENTAL CONSULTANT.

WE WILL, OF COURSE, BE AVAILABLE TO YOU TO DISCUSS THE POSITION WE HAVE TAKEN. SHOULD YOU, HOWEVER, WISH TO TAKE THIS MATTER UP WITH THE NEW HAMPSHIRE INSURANCE DEPARTMENT, IT MAINTAINS A SERVICE DIVISION TO INVESTIGATE COMPLAINTS AT 21 SOUTH FRUIT ST., SUITE 14, CONCORD NH 03301. THE NEW HAMPSHIRE INSURANCE DEPARTMENT CAN BE REACHED, TOLL FREE, BY DIALING 1-800-852-3416.

THE AMOUNT SHOWN AS TOTAL PATIENT PAYMENT TO PROVIDER IS THE AMOUNT PAYABLE TO THE PROVIDER. UP TO DATE BENEFIT INFORMATION, INCLUDING MAXIMUM DOLLARS REMAINING, IS AVAILABLE ON OUR WEBSITE AT NEDELTA.COM.