[Insert logo image here]

[Fund name
Address
City, State, Zip Code]

DHAVAL PATEL DDS INC
620 E ALVIN DR STE F
SALINAS, CA 93906-3054

Explanation of Dental Benefits

Issue Date:	07/27/2022
Total Payment:	$296.00

RIGHT TO APPEAL: If your claim is denied, in whole or in part, you have the right to appeal the denial. Please refer to the Plan's appeal procedure (Article XVI of Plan Regulations)

MEMBER NAME	MEMBER ID	PATIENT	RELATION	PROVIDER NAME	PROVIDER NUMBER	CLAIM NUMBER
PETE AMARO	XXX-XX-8361*0	PETE AMARO	M	DHAVAL PATEL DDS INC	463305226	PR2946

DATE OF SERVICE	BENEFIT DESCRIPT.	TOOTH / SURFACE	AMOUNT BILLED	AMOUNT EXCLUDED	PLAN ALLOWED	LESS DEDUCT/ COPAY APPLIED	%	PLAN COVERED	COB ADJUST	PLAN BENEFIT	PATIENT LIABILITY	COMMENTS
	PERIODONTICS		$275.00	$0.00	$148.00		90	$133.20		$133.20	$14.80	A
	PERIODONTICS	LL	$275.00	$0.00	$148.00		90	$133.20		$133.20	$14.80	A
	TOTALS		**$550.00**	**$0.00**	**$0.00**	**$0.00**		**$266.40**	**$0.00**	**$266.40**	**$29.60**	

Comment/Denial:

A. ***THIS AMOUNT REFLECTS THE FIRST DENTAL HEALTH EPO DISCOUNT*** PATIENT IS ONLY RESPONSIBLE FOR EPO/PPO DISCOUNTED FEE ON ALL DENIED PROCEDURES.

MEMBER NAME	MEMBER ID	PATIENT	RELATION	PROVIDER NAME	PROVIDER NUMBER	CLAIM NUMBER
PETE AMARO	XXX-XX-8361*0	PETE AMARO	M	DHAVAL PATEL DDS INC	463305226	PR2947

DATE OF SERVICE	BENEFIT DESCRIPT.	TOOTH / SURFACE	AMOUNT BILLED	AMOUNT EXCLUDED	PLAN ALLOWED	LESS DEDUCT/ COPAY APPLIED	%	PLAN COVERED	COB ADJUST	PLAN BENEFIT	PATIENT LIABILITY	COMMENTS
	PGYBCK PERIO		$275.00	$0.00	$14.80		100	$14.80		$14.80	$0.00	
	PGYBCK PERIO		$275.00	$0.00	$14.80		100	$14.80		$14.80	$0.00	
	TOTALS		**$550.00**	**$0.00**	**$0.00**	**$0.00**		**$29.60**	**$0.00**	**$29.60**	**$0.00**	

Comment/Denial: