How to read a Predetermination of Dental Benefits

Use the alphabetical glossary of terms below to help you navigate your Predetermination of Dental Benefits.

Sample of a Predetermination of Dental Benefits

<table>
<thead>
<tr>
<th>DOS</th>
<th>TH</th>
<th>CODE</th>
<th>PROCEDURE</th>
<th>TOTAL CHARGE</th>
<th>ALLOWED</th>
<th>DEDUCT</th>
<th>% BENEFIT</th>
<th>CD*</th>
<th>AP**</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>E2</td>
<td>1760</td>
<td>Crown/Post/Gold</td>
<td>$856.00</td>
<td>$816.00</td>
<td>$40.00</td>
<td>50.00</td>
<td>$384.00</td>
<td>SAP</td>
</tr>
<tr>
<td>30</td>
<td>E2</td>
<td>2992</td>
<td>Resin/2 Surf Pits</td>
<td>$156.00</td>
<td>$160.00</td>
<td>$40.00</td>
<td>50.00</td>
<td>$95.40</td>
<td>SAP</td>
</tr>
<tr>
<td>29</td>
<td>E2</td>
<td>8650</td>
<td>Buildup w/Pins</td>
<td>$258.00</td>
<td>$240.00</td>
<td>$18.00</td>
<td>50.00</td>
<td>$120.00</td>
<td>SAP</td>
</tr>
</tbody>
</table>

**ALTERNATE PROCEDURE**

**PROC**

**S18** Tooth colored (composite) fillings on back teeth are not a benefit. Allowance has been made for a silver (amalgam) filling.

*SAP* Provider discount has been applied.

Allowed: Total charge less any disallowed or denied charges. The plan’s benefits are applied towards the amount listed in this column. Disallowed or denied charges can include:

- Provider write-offs due to charges over the maximum plan allowance
- The difference between the allowed charges of the procedure and any alternate benefit given due to contractual limitations or based on Dental Consultant review
- Any amount over the patient’s annual or lifetime maximum

AP** (Alternate Procedure): Refer to **Alternate Procedure

**Alternate Procedure**: The alternate procedure being given to a requested procedure. This can include contractual limitations and alternate benefits being given based on Dental Consultant review

Benefit: The total estimated amount ODS Dental will pay for services

CD* (Comments): Refer to “Code and Comments

Claim No: The predetermination claim number generated by our system

Code: The CDT (Current Dental Terminology) procedure code number

*Code and Comments: The explanation codes and other information regarding the benefits

Deduct: (Deductible) Charges which have been applied to the plan’s deductible. Any amounts listed in this column are patient responsibility

**Dental Benefits and Plan information:** The deductible and maximum amount payable per year, including when the new benefit year begins

**DOS** (Date of Service): The date the service was provided. Since treatment has not been rendered, this column will be blank

over
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Group: Name of insured’s group or employer

Group ID: Insured’s group number

Important: General information regarding the predetermination of dental benefits

Patient Name: The name of the patient

% (Percentage): Percentage at which the requested procedure is reimbursed

Procedure: A description of the service being requested

Provider Name: The name of provider requesting the predetermination of treatment

Subscriber Information: The name of the insured

Subscriber ID: Insured’s identification number

Tax ID: The provider’s tax ID #

TH: Tooth number, when applicable, on which the service is being requested

Total Charge: The amount charged for the requested service

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