DELTA DENTAL
Washington Dental Service
PO Box 75983
Seattle, WA 98175-0688
(206) 522-2300 or (800) 554-1907

Explanation of Benefits

Not a Bill

MICHAEL LAHAM
26841 LA ALAMEDA
APT 636
MISSION VIEJO, CA 92691-7364

45743

What Elana Laham's debt to Ed Samra was

erroneous charge 78.00 by ED SAMRA

Payment Summary

Total Approved Charges	$	107.00
WDS Paid Your Provider	$	107.00
Your Other Insurance Paid	$	0.00
Applied To Deductible/Overmax	$	0.00
Provider Write-Off	$	14.00
Your Total Responsibility	**$**	**0.00**

See below for additional payment information

PATIENT:	ELANA LAHAM
PATIENT DATE OF BIRTH:	[redacted]
SUBSCRIBER (MEMBER) ID:	XXX-XX-X298
GROUP ID:	04400-00200
GROUP NAME:	BOEING NETWORK-CALIFORNIA
BENEFIT PERIOD:	01/01/2005 - 12/31/2005
PLAN MAXIMUM:	$ 2000.00
ORTHO MAXIMUM:	$ 2000.00
ORTHOGNATHIC MAXIMUM:	$
TMJ MAXIMUM:	$
ACCIDENT MAXIMUM:	$
IMPLANT MAXIMUM:	$

CLAIM NUMBER:	200521710444700
DATE PAID:	08/25/2005
CHECK #:	1361259
Used to Date:	$ 107.00
Used to Date:	$
Used to Date:	$
Used to Date:	$
Used to Date:	$
Used to Date:	$

78.00 FW
-42.00 BW
36.00
(Double Dip NO But wrongful charge)

PROVIDER LICENSE #: 41335 **PROVIDER STATE:** CA

PROVIDER NAME: ED SAMRA **ADDRESS:** 27725 SANTA MARGARITA PKWY, STE 261 MISSION VIEJO, CA 926916708

TOOTH	DESCRIPTION OF SERVICE	SUBMITTED PROCEDURE CODE	PAID PROCEDURE CODE	DATE OF SERVICE	SUBMITTED AMOUNT	APPROVED AMOUNT	ALLOWED AMOUNT	DEDUCTIBLE /OVERMAX	PAYMENT LEVEL %	WDS PAID	PROVIDER WRITE-OFF	PROCESSING POLICIES
	Comp Oral Eval	D0150	D0150	07/25/2005	29.00	29.00	29.00	0.00	100	29.00	0.00	
	BW-Four Films	D0274	D0274	07/25/2005	0.00	0.00	0.00	0.00	0	0.00	0.00	044
	FM X-ray Inc BW	00210	D0210	07/25/2005	92.00	78.00	78.00	0.00	100	78.00	14.00	
	X-ray-1st PA	D0220	D0220	07/25/2005	0.00	0.00	0.00	0.00	0	0.00	0.00	044
	X-ray-Addl PA	D0230	D0230	07/25/2005	0.00	0.00	0.00	0.00	0	0.00	0.00	044
	X-ray-Addl PA	D0230	D0230	07/25/2005	0.00	0.00	0.00	0.00	0	0.00	0.00	044
	X-ray-Addl PA	D0230	D0230	07/25/2005	0.00	0.00	0.00	0.00	0	0.00	0.00	044
	X-ray-Addl PA	D0230	D0230	07/25/2005	0.00	0.00	0.00	0.00	0	0.00	0.00	044
	X-ray-Addl PA	D0230	D0230	07/25/2005	0.00	0.00	0.00	0.00	0	0.00	0.00	044
CLAIM TOTALS:					**121.00**	**107.00**	**107.00**	**0.00**		**107.00**		

Attempted to double bill — bite wing x-rays

Erroneous — full mouth x-rays

PROCESSING POLICIES

044 - Any individual or combination of x-rays (periapical, bitewing, occlusal, or panoramic) is considered a complete series if the cost equals or exceeds the cost for a complete series. Participating dentists have agreed to charge the patient only the amount indicated as the patient's responsibility.

Without my permission he took full mouth x-ray

GENERAL INFORMATION

You can now get instant access to information about your dental coverage, including claims status and procedures covered, by going online to www.DeltaDentalWA.com. To ensure your security, you will be prompted through a one-time registration process on your first visit. For information on claims processed prior to July 1, 2004, call customer service at 1-877-377-5727.

It's healthier insurance

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Explanation of Benefits

Not a Bill

MICHAEL LAHAM
26841 LA ALAMEDA
APT 636
MISSION VIEJO, CA 92691-7364

8978

Payment Summary

Total Approved Charges	$	397.00
WDS Paid Your Provider	$	277.60
Your Other Insurance Paid	$	0.00
Applied To Deductible/Overmax	$	50.00
Provider Write-Off	$	0.00
Your Total Responsibility	**$**	**119.40**

(*) What Elana Laham's debt to Ed Samra was

See below for additional payment information

PATIENT: ELANA LAHAM
PATIENT DATE OF BIRTH: [illegible]
SUBSCRIBER (MEMBER) ID: XXX-XX-X298
GROUP ID: 04400-00200
GROUP NAME: BOEING NETWORK-CALIFORNIA
BENEFIT PERIOD: 01/01/2005 - 12/31/2005

CLAIM NUMBER: 200522710479700
DATE PAID: 09/01/2005
CHECK #: 1372100

PLAN MAXIMUM:	$ 2000.00	**Used to Date:**	$ 384.60
ORTHO MAXIMUM:	$ 2000.00	**Used to Date:**	$
ORTHOGNATHIC MAXIMUM:	$	**Used to Date:**	$
TMJ MAXIMUM:	$	**Used to Date:**	$
ACCIDENT MAXIMUM:	$	**Used to Date:**	$
IMPLANT MAXIMUM:	$	**Used to Date:**	$

PROVIDER LICENSE #: 41335 **PROVIDER STATE:** CA
PROVIDER NAME: ED SAMRA **ADDRESS:** 27725 SANTA MARGARITA PKWY, STE 261 MISSION VIEJO, CA 926916708

TOOTH	DESCRIPTION OF SERVICE	SUBMITTED PROCEDURE CODE	PAID PROCEDURE CODE	DATE OF SERVICE	SUBMITTED AMOUNT	APPROVED AMOUNT	ALLOWED AMOUNT	DEDUCTIBLE /OVERMAX	PAYMENT LEVEL %	WDS PAID	PROVIDER WRITE-OFF	PROCESSING POLICIES
29	RCT Bicusp	D3320	D3320	08/05/2005	397.00	397.00	347.00	50.00	80	277.60	0.00	
CLAIM TOTALS:					**397.00**	**397.00**	**347.00**	**50.00**		**277.60**		

(*) 347.00
− 277.60
69.40
+ 50.00
119.40 (Patient Portion includes deductible I pay) (what I owe)

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