

Insurance Company Name
123 Benefit Lane
City, State, Zip Code

Date: [Insert Date]

Member Name: [Insert Name]
Member ID: [Insert ID Number]
Claim Number: [Insert Claim Number]

Explanation of Benefits (EOB)

This is not a bill. This statement provides details regarding a recent dental claim processed under your dental plan.

Date of Service	Procedure Code	Provider Billed	Plan Allowance	Deductible	Co-pay / Co-insurance	Total Payout
[Date]	[Code]	[\$[0.00]]	[\$[0.00]]	[\$[0.00]]	[\$[0.00]]	[\$[0.00]]

Summary of Claim Payout:

- **Total Amount Billed:** \$[0.00]
- **Plan Paid to Provider:** \$[0.00]
- **Patient Responsibility:** \$[0.00]

Payment Details:

A payment in the amount of \$[0.00] was issued to [Provider Name/Member Name] on [Check Date] via [Check Number/Electronic Transfer].

Notes / Remarks:

[Insert codes or explanations for denied or partially paid services here.]

If you have questions regarding this claim, please contact our Customer Service department at [Phone Number] or visit our member portal at [Website URL].

Sincerely,
Claims Department
[Insurance Company Name]