

DATE(S) OF SVC		PROC CODE	PROVIDER CHARGE	NON-CHARGE ABLE	SUBSCRIBER LIABILITY	OTHER INSURANCE AMOUNT	AMOUNT(S) PAID TO PROVIDER	AMOUNT(S) PAID TO SUBSCRIBER	MESSAGE CODE(S)
NUM OF SVCS	PL OF SVC	TOOTH NUMBER/SURFACES	ALLOW -ANCE	/ NON- CHG CODE	/ SUB LIAB CODE				

Claim Number: [REDACTED]

Patient: [REDACTED]

ID Number: [REDACTED]

Patient Acct #: [REDACTED]

Appl/Sub Name: [REDACTED]

10/29/25		D1110	71.50				71.50		J9752
1	O		71.50						
10/29/25		D0230	16.15		4.84 / C1 1.31 / E1				X5022 J9752
1	O		16.15						
10/29/25		D0220	19.15		5.74 / C1 6.60 / E1		6.81		J9752
1	O		19.15						
Claim Totals:				.00	78.69	.00	138.86	.00	

MESSAGE(S):

- A8279 No payment can be made. This service is limited to one per benefit period.
- J9752 If you have any questions, call the Dental Customer Service Unit at 808-948-6440 on Oahu or toll free 1-800-792-4672.
- X5022 No payment can be made. The maximum benefit amount available under the patient's coverage has been paid.

EOB Totals:	Total Subscriber Payments:\$00	Total Provider Payments: [REDACTED]	Payment Number: [REDACTED]
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SUBSCRIBER LIABILITY CODES:

- C1 Coinsurance
- E1 Benefit maximum has been reached
- H1 Rejected Billable Non-Covered Service