ATTACHMENT I

Detailed General Excise Tax Report – Provider Payment

UCD Billing Provider ID - XXXXXXXXX

UCD Rendering Provider ID – XXXXXXXXX

Rendering Provider Name – XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXX

Rendering Provider Zip Code – XXXXX

Claim Number	Contract ID	Patient Name
XXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXX

Date of Service	Procedure Code	Eligible Amount	Tax Rate	Excise Tax Paid
YYYYMMDD	XXXXX	XXXXXXXXXX.XX	X.XXX	XXXXXXXXXX.XX
YYYYMMDD	XXXXX	XXXXXXXXXX.XX	X.XXX	XXXXXXXXXX.XX

Excise Tax Paid – Total Claim

XXXXXXXXXX.XX

THIS DETAILED PROVIDER REPORT WILL BE AVAILABLE AT MYDENTALCOVERAGE.COM (log into bshi.net)