



DENTIST'S CLAIM FORM

Check	Dentist's pre-treatment estimate
One:	Dentist's statement of actual services

UNITED CONCORDIA TDP OCONUS Dental Unit P.O. Box 69452 Harrisburg, PA 17106 USA

Form Approved OMB OMB#0720-0035 Expires TBD



	1. Patient name				2. Relation	onship to spouse	sponsor child	othe	3. Sex	4. Patient mo	birthdat day	te ye		II-time stude school	ent	city			
P A	6. Sponsor's name First	Midd	lle		Last				11. Branch	of service									
T I	7.Sponsor's Social Security number (SSN) or Dental Benefits Number (DBN)								12. Group name TRICARE Dental Program										
	8. Patient mailing address (APO/FPO or street, city, country, postal mailing code)								13. Is patient covered by Dental plan name another dental plan?										
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E	9. Telephone number (inclu	7. Telephone number (include country, city, and/or area code)									Name and address of carrier								
TION		I have reviewed the following treatment plan. I authorize release of any information relating to this claim.							14. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to the dentist listed below.										
14																			
	Signature (patien	t or parer	it ii iiiiiioi)			ate			Signature (ir contact (PC				o., fax no., a	and email addres	Date			
D									21. Point of contact (POC) name, telephone no., fax no., and email address										
E N T	16. Office address	Street, city, country, postal mailing code								tment result upational or injury?									
S	16a. Billing address			Street city	country no	etal mailii	na code			accident?									
T S E	roa. Dilling address	ng address Street, city, country, postal mailing code								esis, is			(If no, reason for replacement) 26. Date of prior placement						
CT	17. Dentist phone no. (inclu		ntry, city,	and/or area		27. Is treatnorthodo	nent for			Appliance insertion date Total length of treatment									
0 N	19. Dentist fax no.		20.	. Dentist emai	l address				28. Transfe	patient?				Availability band date	lf ı	orm Necessary) no, starting date of			
										Was patient rebanded?									
Indicate tooth/ teeth no.(s) for which services were 29. Examination and treatment plan—list in order from Tooth No.										ooth No. 3	2—Use				1				
	provided. OR LETTER U.S., INT'L TOOTH NO. OR SURFACE (INCLUDING X-RAYS, PROPHYLA								VICES				DATE SERVICE PERFORMED PROCEDURE CODE			FEE CHARGED			
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	PRIMARY PRIMARY AN ILLUST RICHARY BIRDOT																		
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	27 26 25 24 LABIRI																		
	30. Remarks for unusual services																		
31. Any person who knowingly files a statement of claim containing any misrepresentation or false, incomplete, misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a criminal act under state and/or federal law and may also be subject to civil penalties. The signer agrees that any personally identifiable health information about the 32. TOTAL FEE CHARGED									AMOUNT PAID										
signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privace laws. In accordance with those laws, United Concordia may use and disclose Protected Health Information for treatment, payment an health care operations as described in its Notice of Privacy Practices. I hereby certify that the procedures as indicated by date have b completed.								nent and	b	33. INDICATE CURRENCY									
Signature (Dentist) Date								ate					us	SD					

Completing the TDP OCONUS Claim Form

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, East Tower, Suite 03F09, Alexandria, VA 22350-3100 (0720-0035). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid Office of Management and Budget (OMB) control number. Please do not return your response to the above address. Responses should be sent to the address provided below.

The completed form should be sent to:

United Concordia, TDP OCONUS Dental Unit, P.O. Box 69452, Harrisburg, PA 17106 USA

Most of the TDP OCONUS Claim Form is self-explanatory; however, there are certain fields to which special attention should be paid:

- **Upper left corner.** <u>Dentist's Claim Form</u>: Check the appropriate box to indicate if your claim is for predetermination (estimate of services to be performed) or for services actually received.
- Box 2. Relationship to sponsor: For example, self, spouse, or child.
- Box 7. Sponsor's Social Security number (SSN) or Dental Benefits Number: The sponsor's nine-digit SSN or 11-digit DBN must appear on every claim form.
- Box 8. <u>Patient mailing address</u>: Be sure to provide the current and complete mailing address to include APO/FPO and/or street, city, country, and postal mailing code.
- Box 10. Release of Information
- Box 13. <u>Is patient covered by another dental plan?</u>: Check "No" if the family member has no other dental insurance. If the family member has additional dental insurance, please check "Yes" and include the plan name, insured name and Social Security number, group number, and address of the other carrier.
- Box 14. <u>Assignment of Benefits</u>: Sign if the family member, parent, or guardian wants to assign payment of benefits to the dentist; if signed, United Concordia will send payment to the dentist directly.
- Box 15. Dentist name
- Box 16. Office address: Include street, city, country, and postal mailing code where services were performed.
- Box 16a. Billing address: Include street, city, country, and postal mailing code.
- Box 17. Dentist phone no.: Include the country code and city code, along with local number.
- Box 27. <u>Is treatment for orthodontics?</u>: For orthodontic care, submit a completed copy of this claim form along with a valid Non-Availability and Referral Form and the provider's bill to the address on the front of this form.
- Box 29. Examination and treatment plan: Provide a detailed description of the services performed, including applicable tooth numbers, date of service, and the fee charged.
- Box 33. Indicate Currency: Indicate type of currency billed to patient (U.S. dollars or local currency).

General Instructions

- Submit a separate claim form for each family member who receives treatment.
- All claim forms should be submitted to United Concordia as soon as possible after the service date, preferably within 60 days of the date of service. Claims postmarked more than 12 months after the date of service will be denied.

United Concordia, TDP OCONUS Dental Unit P.O. Box 69452 Harrisburg, PA 17106 USA Phone: 844-653-4060
Fax number: 844-827-9926
Email: TDP_OCONUS@ucci.com

- The family member must sign the appropriate sections of the claim form. If the family member is under 18 years old, the parent or guardian must sign the form.
- The provider must sign the appropriate sections of the claim form.
- · For orthodontic services, submit the following:
 - 1. A completed claim form
 - 2. The dentist's bill (if the claim form is not used solely as the bill)
 - 3. A Non-Availability and Referral Form

If all necessary information is not included, your claim may be denied.