

UNITED CONCORDIA®

As a federal contractor, United Concordia is bound by contract and law to adhere to the Privacy Act. The Privacy Act of 1974 was established to guard against an invasion of privacy of any record retained on an individual by a Government agency. It is important to understand the restrictions the Privacy Act places on the customer service we can provide to you. Some of the restrictions are:

- Personal information can only be released to the family member to whom the information pertains if the family member is age 18 or older; unless United Concordia receives written authorization.
- Parents or legal guardians of children under age 18 can receive information on the minor child, provided the relationship to the minor can be established.
- Prior to requesting information, a legal guardian or custodial parent must establish proof of guardianship, in writing, to United Concordia.

The Custodial parent Release form(s) will allow United Concordia to issue all correspondence directly to the custodial parent, as well as payment* for services provided to minor children by network or non-network dentists. The Custodial parent Release form(s) must be completed and signed by the sponsor and custodial parent. In lieu of the signed Custodial parent Release form(s), a valid court order or proof of guardianship can be accepted. If sending a Court Order or Proof of Guardianship, please be sure to include the sponsor's social security number and your name and address.

Court orders must contain the following information:

- The page containing the names of the plaintiff and defendant
- The page containing the name(s) of the child/children
- The page containing the custody order (who has custody, joint or sole custody)
- The page containing the judge's signature

Proof of Guardianship must contain the following information:

- The name and address of appointed guardian
- The name(s) of the child/children that the guardianship applies to
- If applicable, the dates of duration for the guardianship

*Payment: The recipient of payment is determined by the dentist's network status and if the services were paid for during the office visit.

CUSTODIAL PARENT RELEASE

_____ (Sponsor's Full Name)
_____ (Sponsor's SSN or DBN)
_____ (Group Name)

_____ (Type of Coverage – Full, Partial, Limited)

_____ (Type of Custody – Full, Shared)
_____ (Parent's Full Name)
_____ (Parent's Address 1)
_____ (Parent's Address 2 – optional)
_____ (Parent's City)
_____ (Parent's State)
_____ (Parent's ZIP Code)

_____ (Dependent Child's Full Name)

*Please attach any relevant documentation when submitting this form.

- The above referenced Sponsor acknowledges that he/she has health care coverage through United Concordia Companies, Inc. The group's name, identification number and the Sponsor's identification numbers have been accurately set forth above.
- The Sponsor hereby acknowledges that he/she and the above named custodial parent are divorced/separated and that he/she is required to provide health care coverage for the above named family member child pursuant to a valid court issued support order.
- By way of this agreement, the Sponsor directs the Plans henceforth to communicate directly with the above named custodial parent regarding claims processed on the behalf of the above named family member.
- The Sponsor acknowledges that because he/she has directed the Plans to communicate directly with the custodial parent regarding payment of claims and to pay claims directly to the custodial parent and because of the confidential nature of medical records and information, that the Plans are not obligated to provide any information to the Sponsor regarding the payment of claims incurred by the eligible family member.
- Both the Sponsor and the custodial parent acknowledge that this release shall remain in effect until withdrawn by the Sponsor.
- Withdrawal of this release shall be made in writing on the form provided by the Plans, and the Sponsor shall provide the custodial parent with written notice of the withdrawal of this release at the same time that notice is provided to the Plans.
- The Sponsor hereby releases and discharges the Plans from any and all claims, causes of action, damages and/or liability, arising out of the Plans' communication or payment of claims on behalf of the family member directly to the custodial parent.
- The custodial parent hereby acknowledges that failure to provide the Plans with a correct mailing address or failure to inform the Plans of a change in address may result in claims being improperly processed. The custodial parent hereby releases and discharges the Plans from any and all claims, causes of action, damages and/or liability arising out of the Plans' misdirection of claims information or claims payments if such was the result of misinformation or insufficient information obtained from the custodial parent.

Custodial Parent's Signature

Sponsor Signature's

Date

Date

Please return the completed form to:

United Concordia Companies, Inc
 TDP Customer Service
 P.O. Box 69450
 Harrisburg, PA 17106

OPTIONAL:

By completing the statement below, the custodial parent authorizes the non-custodial parent to receive information on the dependent child/children indicated on this form:

I hereby authorize and approve the release to _____, any and all records and patient files in your possession which refer, relate or pertain to _____ (child's name). I understand the authorization will remain in effect indefinitely, unless I revoke the authorization in writing.

CUSTODIAL PARENT'S SIGNATURE

(If child is under 18 years of age)

BENEFICIARY'S SIGNATURE

(If 18 years or older)

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by the TRICARE Dental Program (TDP) and how it will be used.

AUTHORITY:	10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.13, TRICARE Dental Program; and E.O. 9397 (SSN), as amended.
PURPOSE:	To collect information from you to manage your enrollment in the TDP, administer your benefits, and pay for the services you receive.
ROUTINE USES:	Your records may be disclosed to providers of care and other business entities on matters relating to eligibility, claims pricing and payment, fraud, quality assurance, program integrity, and the coordination of benefits. Your records may also be disclosed outside of the Department of Defense (DoD) in accordance with the DoD Blanket Routine Uses published at http://dpclid.defense.gov/Privacy/SORNSIndex/Blanket-Routine-Uses/ and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.
DISCLOSURE:	Voluntary. If you choose not to provide this information, no penalty may be imposed, but absence of the requested information may delay or prevent your receipt of TDP services.