United Concordia

Power of Attorney Submission Form

Your Name
 Subscriber Name
Subscriber SSN or DBN
Your Email address
 _ Your Daytime phone number
 Your Address
 Your City
Your State
Your ZIP Code

Comments

Please return the completed form to:

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

^{*}Please attach any relevant documentation when submitting this form.

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 Caution-http://dpcld.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.