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 attach any relevant documentation when submitting this form.

Please return the completed form to:

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

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.