TRICARE | United Concordia

Form Approved OMB
No. TBD
Expires TBD

HEADER INFORMATION

1. Type of Transaction (*Mark all applicable boxes*)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

United Concordia
TRICARE Dental Program
P.O. Box 69451
Harrisburg, PA 17106

OTHER COVERAGE (Mark applicable box and complete 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (if both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (*Last, First, Middle Initial, Suffix*)

6. Date of Birth (*MM/DD/CCYY*)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

SPONSOR INFORMATION (For Insurance Company Named in #3)

12. Sponsor's Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (*MM/DD/CCYY*)	14. Gender ☐ M ☐ F	15. Sponsor SSN or DoD Benefits Number (DBN)
16. Plan/Group Number	17. Employer Name: TRICARE Dental Program	

PATIENT INFORMATION

18. Relationship to Sponsor in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Full Time Student / School

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (*MM/DD/CCYY*)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16
☐32 ☐31 ☐30 ☐29 ☐28 ☐27 ☐26 ☐25 ☐24 ☐23 ☐22 ☐21 ☐20 ☐19 ☐18 ☐17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "**A**") B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I certify the above information is correct. X _____
Subscriber Signature Date

38. I authorize payment of the dental benefits directly to the below named dentist or entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

39. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital)
(Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (*MM/DD/CCYY*)

42. Months of Treatment Remaining:
43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)
44. Date of Prior Placement (*MM/DD/CCYY*)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN
52. Additional Provider ID	52a. Phone Number ( ) -	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID

INSTRUCTIONS FOR COMPLETING:

TRICARE® Dental Program CONUS Claim Form

OMB No. TBD
OMB approval expires XX-XX-XXXX

Information for Sponsor/Patient

1. Complete your section of the claim form (items 1–21 and 36-37) in full to assure positive identification and prompt payment. Please print or type. **Note:** Item 15, Sponsor Social Security number (SSN) or Department of Defense Benefits Number (DBN), **must be completed** for the claim to be processed.
2. **Patient consent.** By signing item 36, the **patient** (or parent or other authorized representative) consents to the use and disclosure of information relating to the services provided by the dentist or health care provider for the purpose of treatment, payment, or health care operations, including submission of a claim for dental benefits to a provider or administrator of dental benefit plans. This consent will be valid for as long as the patient is entitled to coverage under a dental plan. You are entitled to a copy of this consent. This consent may be revoked in writing and delivered to your dentist or health care provider, but such revocation will not affect any action taken in reliance on this consent prior to revocation. Upon receipt of revocation or refusal to sign a consent, your dentist or health care provider may decline to provide or continue treatment. If this consent is signed by the authorized representative of the patient, the relationship of the authorized representative must be provided in item 36.
3. The patient, if 18 or older, must sign the claim form in item 37.
4. You can arrange for the TRICARE Dental Program (TDP) contractor to make payment directly to the dentist by completing item 38. If you wish to receive payment directly, do not complete item 38. In either case, a dental explanation of benefits paid will be sent to you.
5. A pre-treatment estimate is recommended for treatment plans involving onlays, single crowns, implants, prosthodontics, periodontics, orthodontics, and oral surgery services. This allows the dentist and the patient to know, prior to receiving treatment, if the proposed service(s) will be covered by the dental care plan and the anticipated amount of payment. The completed claim form should be sent to the address below prior to the commencement of the course of treatment. The TDP contractor will notify you of your benefits payable.

Dental coverage is subject to specific limitations and exclusions.
Please visit www.tricare.mil/dental or call your TDP contractor for more information.

Information for Attending Dentist

1. Benefits are payable in accordance with four classes of services. Therefore, it is important that a separate fee is indicated for each item of service performed.
2. A pre-treatment estimate is recommended for treatment plans involving onlays, single crowns, implants, prosthodontics, periodontics, orthodontics, and oral surgery services. The completed claim form should be sent to the address below prior to the commencement of the course of treatment. The TDP contractor will review the claim (and any supplemental information required) and notify your patient of the benefits payable.
3. If the address where treatment was performed is different from the mailing address in item 48, complete item 56.
4. Generally, the TDP contractor does **not** request X-rays where standard filling materials are used. Pre-operative X-rays are requested **only** in connection with prosthetics, fixed bridgework, or cast restorations. Occasionally, the TDP contractor may request X-rays that relate to other dental services.

   In an effort to reduce your costs and inconvenience, the TDP contractor requests your cooperation in submitting X-rays **only** in the above-mentioned circumstances or when specifically requested. This will also enable the TDP contractor to expedite the processing of a pre-treatment estimate.
5. If authorized by the sponsor/patient, benefit payments will be made directly to you.

Mail or fax the completed *TRICARE Dental Program CONUS Claim Form*. Call if you need assistance completing the form.

United Concordia TRICARE Dental Program
P.O. Box 69451 Harrisburg, PA 17106

Phone: 844-653-4061
Fax number: 717-635-4565