INSTRUCTIONS FOR COMPLETING:

TRICARE® Dental Program
OCONUS Non-Availability and Referral Form (NARF)

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

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, Information Management Division, 4800 Mark Center Drive, East Tower, Suite 02G09, 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.**

Patient information and referral information fields must be completed by the servicing overseas dental treatment facility (ODTF) or TRICARE Area Office (TAO) Dental Consultant. If patient is under age 18, the parent or guardian must sign on his or her behalf.

1. **Patient's name:** Enter the last name, first name, and middle initial of the person being treated as it appears on the uniformed services identification (ID) card.
2. **Date of birth:** Enter the month, day, and year of the patient's birth.
3. **Gender:** Check the appropriate box for the patient.
4. **Relationship to sponsor:** Check the appropriate box for the patient.
5. **Sponsor's name:** Enter the last name, first name, and middle initial of the sponsor as it appears on the uniformed services ID card.
6. **Sponsor's Social Security number (SSN) or Department of Defense Benefits Number (DBN):** Enter the sponsor's SSN or DBN.
7. **Patient's address:** Enter the home mailing address of the patient seeking dental treatment. Be sure to provide the complete address (Unit/P.O. Box/street, city, APO/FPO, country code, and postal mailing code).
8. **Sponsor's and patient's phone number:** Enter the sponsor's and patient's phone numbers including area code or country code.
9. **Referring ODTF/TAO:** Enter the name of the ODTF/TAO and the country where the referral will take place.
10. **Primary reason for referral:** Check the appropriate box.
11. **Orthodontic referred service:** Ensure referrals are made for specific care and include the applicable current dental terminology (CDT) code(s), if possible, tooth number(s), and procedure name.
12. **Command sponsorship/time on station (OCONUS):** (a) Check the appropriate box for command sponsorship status. **Note:** This will be confirmed through the Defense Enrollment Eligibility Reporting System (DEERS); (b) Enter the month and year that sponsor began overseas tour; (c) Enter the time left on this overseas tour.
13. **Remarks/Description:** Provide a detailed description of the service for which the patient is being referred. Ensure referrals are being made for specific care and include the applicable current dental terminology (CDT) code(s) if possible and procedure name.
14. **Name and title:** Enter the name and title of the person issuing the referral form.
15. **Approval signature:** Enter the signature of the person issuing the referral form.
16. **Date of issuance:** Enter the date the referral form is provided to the patient.
17. **Sponsor/patient certification:** This field must be completed, signed, and dated by the sponsor/patient.
18. **Referring party confirmation:** If this form is being faxed/mailed to a sponsor/patient, the government representative completing the form must initial and date the form after explaining the certification in field 17 to the sponsor/patient.
19. **ODTF/TAO tracking number:** For use by the ODTF/TAO.

Mail, email or fax the completed *TRICARE Dental Program OCONUS Non-Availability and Referral Form* (NARF), *TRICARE Dental Program OCONUS Claim Form*, and the provider's bill for total orthodontic services. Call if you need assistance completing the form or e-mail your questions to (email TBD).

United Concordia TRICARE Dental Program
OCONUS Department
PO Box 69452
Harrisburg, PA 17106

Phone: 844-653-4060
Fax number: 844-827-9926
Email: TBD

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TRICARE Dental Program
OCONUS Non-Availability and Referral Form (NARF)

Note: This form is only necessary for OCONUS orthodontic care. This complete form, along with the *TRICARE Dental Program OCONUS Claim Form* and the provider's total bill should be sent to your dental insurance provider for processing. Additional information can be found at www.tricare.mil/dental.

Patient Information

1. Patient's name — Last / First / MI

2. Date of birth (mm/dd/yyyy)

3. Gender — M ☐ F ☐

4. Relationship to sponsor — Spouse ☐ Child ☐ Other ☐

5. Sponsor's name — Last / First / MI

6. Sponsor's SSN or DBN

7. Patient's address (Unit/P.O. Box/street, city, APO/FPO, country code, and postal mailing code)

8. Sponsor's phone number:

   Patient's phone number:

Referral Information

9. Referring ODTF/TAO (name and location)

10. Primary reason for referral
    - ☐ Proper facilities or professional capability are temporarily not available at this facility
    - ☐ Proper facilities or professional capability are permanently not available at this facility

11. Orthodontic referred service (include CDT code(s) if possible)
    - ☐ Diagnostic ☐ Comprehensive
    - ☐ Limited ☐ Retainer

    CDT codes: (if possible)

12. Command sponsorship/time on station (OCONUS)
    - a) Command-sponsored? ☐ Yes ☐ No
    - b) Date sponsor reported to OCONUS duty station
    - c) Time (years/months) sponsor has left on OCONUS orders

13. Remarks/Description

14. Name and title (type or print)

15 Approval signature

16. Date of issuance*

* Form valid for 120 days from date of issuance.

Sponsor/Patient Certification

17. Sponsor/patient certification

    I have confirmed my enrollment in the TRICARE Dental Program. If I am not enrolled, I am responsible for the full cost of any dental care received.

    I confirm that as of the date of this referral, I have not exceeded the appropriate lifetime orthodontic maximum. I understand that, if I have exceeded my maximum ($1,750 for orthodontic services), I am responsible for the full cost of any additional orthodontic services received.

    I understand that if I receive services for dental care not covered under this referral, I am responsible for the full cost of any dental care received outside the scope of this referral.

    Signature (sponsor/patient) ____________________ Date ____________

18. Referring party confirmation

    I have received confirmation from the sponsor/patient that the above is true and that the sponsor/patient agrees to these certifications as of the date of this referral.

    Initials (referring party)__________ Date __________

19. ODTF/TAO tracking number