TRICARE | United Concordia

DENTIST'S CLAIM FORM

Check One: ○ Dentist's pre-treatment estimate ○ Dentist's statement of actual services

UNITED CONCORDIA
TRICARE Dental Program
P.O. Box 69452
Harrisburg, PA 17106

Form Approved OMB
OMB#0720-0035
Expires TBD

PATIENT SECTION

1. Patient name

2. Relationship to sponsor: Self ○ Spouse ○ Child ○ Other ○

3. Sex: M ○ F ○

4. Patient Birthdate: Month / Day / Year

5. Sponsor's name: First / Middle / Last

6. Sponsor's Social Security number (SSN) or DoD Benefits Number (DBN)

7. Patient mailing address (APO/FPO or street, city, country, postal mailing code)

8 Telephone number **(include country, city, and/or area code)**

9. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signature (patient or parent if minor) / Date

10. Branch of service

11. Group name

TRICARE Dental Program

12. Is patient covered by another dental plan? ○ yes ○ no

Dental plan name

Insured name and SSN

Group no.

Name and address of carrier

13. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to the dentist listed below.

Signature (insured person) / Date

DENTIST SECTION

14. Treating Facility (name of practice)

15. Treating Doctor (name of dentist)

16. Treating Dentist's license #, issue date/expiration date

17. Address, Phone # and Email address

18. City, mailing code

19. Country

20. Point of contact (POC) name, telephone no., fax no., and email address

	No	Yes	
21. Is treatment result of occupational illness or injury?	○	○	If yes, enter brief description and dates
22. Is treatment result of occupational illness or injury?	○	○	
	○	○	
23. If prosthesis, is this initial placement?	○	○	(If no, reason for replacement) 24. Date of prior placement
25. Is treatment for orthodontics?	○	○	Appliance insertion date / Total length of treatment
			(Non-Availability and Referral Form Necessary)
26. Transfer patient?	○	○	If yes, reband date / If no, starting date of treatment
27. Was patient rebanded?	○	○	

28. Date Format: Please check the Date format that your office uses: Month/Day/Year ○ Day/Month/Year ○ Year/Month/Day ○

TOOTH NO. OR LETTER U.S. ○ INT'L ○	SURFACE	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED	PROCEDURE CODE	FEE CHARGED

29. Any person who knowingly files a statement of claim containing any misrepresentation or false, incomplete, misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a criminal act under state and/or federal law and may also be subject to civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, United Concordia may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices. I hereby certify that the procedures as indicated by date have been completed.

Signature (Dentist) / Date

Pay Member ○
Pay Provider ○

30. TOTAL FEE CHARGED

31. INDICATE CURRENCY
○ USD
○ Foreign
Currency Type

32. AMOUNT PAID BY MEMBER

Completing the TDP OCONUS Claim Form

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, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. 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.**

The completed form should be sent to:
United Concordia, TDP OCONUS Dental Unit, P.O. Box 69452, Harrisburg, PA 17106 USA

Most of the TDP OCONUS Claim Form is self-explanatory; however, there are certain fields to which special attention should be paid:

- **Upper left corner. Dentist's Claim Form:** Check the appropriate box to indicate if your claim is for predetermination (estimate of services to be performed) or for services actually received.
- **Box 2. Relationship to sponsor:** For example, self, spouse, or child.
- **Box 6. Sponsor's Social Security number (SSN) or DoD Benefits Number(DBN):** The sponsor's nine-digit SSN or 11-digit DBN must appear on every claim form.
- **Box 8. Patient mailing address:** Be sure to provide the current and complete mailing address to include APO/FPO and/or street, city, country, and postal mailing code.
- **Box 10. Release of Information**
- **Box 12. Is patient covered by another dental plan?:** Check "No" if the family member has no other dental insurance. If the family member has additional dental insurance, please check "Yes" and include the plan name, insured name and Social Security number, group number, and address of the other carrier.
- **Box 13. Assignment of Benefits:** Sign if the family member, parent, or guardian wants to assign payment of benefits to the dentist; if signed, United Concordia will send payment to the dentist directly.
- **Box 15. Dentist name**
- **Box 17-19. Office and Billing address:** Include street, city, country, and postal mailing code where services were performed.
- **Box 17. Dentist phone no.:** Include the country code and city code, along with local number.
- **Box 25. Is treatment for orthodontics?:** For orthodontic care, submit a completed copy of this claim form along with a valid Non-Availability and Referral Form and the provider's bill to the address on the front of this form.
- **Examination and treatment plan:** Provide a detailed description of the services performed, including applicable tooth numbers, date of service, and the fee charged.
- **Box 31. Indicate Currency:** Indicate type of currency billed to patient (U.S. dollars or local currency).

General Instructions

- Submit a separate claim form for each family member who receives treatment.
- **All claim forms should be submitted to United Concordia as soon as possible after the service date**, preferably within 60 days of the date of service. Claims postmarked more than 12 months after the date of service will be denied.

United Concordia TRICARE Dental
Program P.O. Box 69452
Harrisburg, PA 17106

Phone: 844-653-4060
Fax number: 844-827-9926
Email: TDP_OCONUS@ucci.com

- The family member must sign the appropriate sections of the claim form. If the family member is under 18 years old, the parent or guardian must sign the form.
- The provider must sign the appropriate sections of the claim form.
- For orthodontic services, submit the following:

1. A completed claim form
2. The dentist's bill (if the claim form is not used solely as the bill)
3. A Non-Availability and Referral Form

If all necessary information is not included, your claim may be denied.