UNITED CONCORDIA®
Protecting More Than Just Your Smile®

DENTIST'S CLAIM FORM

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

UNITED CONCORDIA
TDP OCONUS Dental Unit
P.O. Box 69452
Harrisburg, PA 17106 USA

Form Approved OMB No. TBD
Expires TBD

PATIENT SECTION

1. Patient name
2. Relationship to sponsor: self / spouse / child / other
3. Sex: m / f
4. Patient birthdate: mo / day / year
5. If full-time student: school / city
6. Sponsor's name: First / Middle / Last
7. Sponsor's Social Security number (SSN) or Dental Benefits Number (DBN)
8. Patient mailing address (APO/FPO or street, city, country, postal mailing code)
9. Telephone number **(include country, city, and/or area code)**
10. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signature (patient or parent if minor) ____________ Date ____________

11. Branch of service
12. Group name: **TRICARE Dental Program**
13. Is patient covered by another dental plan? ☐ yes ☐ no — Dental plan name
Insured name and SSN — Group no.
Name and address of carrier
14. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to the dentist listed below.

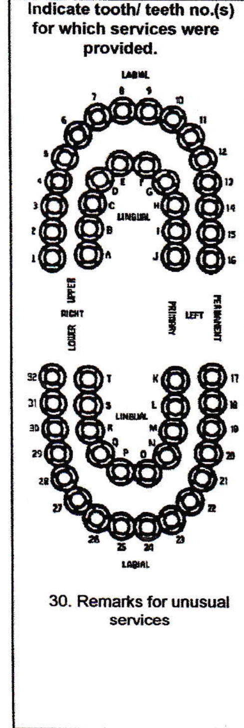
Signature (insured person) ____________ Date ____________

DENTIST SECTION

15. Dentist name
16. Office address — Street, city, country, postal mailing code
16a. Billing address — Street, city, country, postal mailing code
17. Dentist phone no. (including country, city, and/or area code)
18. UCCI dentist no.
19. Dentist fax no.
20. Dentist email address
21. Point of contact (POC) name, telephone no., fax no., and email address

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

Indicate tooth/ teeth no.(s) for which services were provided.



30. Remarks for unusual services

29. Examination and treatment plan—list in order from Tooth No. 1 through Tooth No. 32—Use charting system shown.

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

31. 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 ____________

32. TOTAL FEE CHARGED

AMOUNT PAID

33. INDICATE CURRENCY ☐ USD ☐ LOCAL

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