ATTENDING DENTIST'S STATEMENT

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

UNITED CONCORDIA

TDP OCONUS Dental Unit
P.O. Box 69418
Harrisburg, PA 17106-9418 USA

OMB NO. 0720-0035
EXPIRES:

PATIENT SECTION

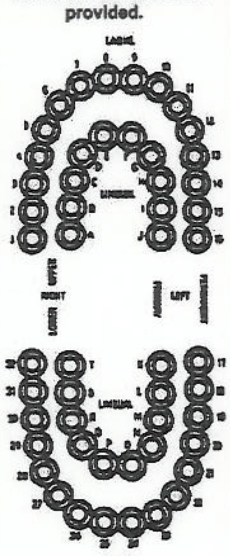
1. Patient name	2. Relationship to sponsor: self / spouse / child / other	3. Sex: m / f	4. Patient birthdate: mo / day / year	5. If full time student: school / city

6. Sponsor's name: First / middle / last	11. Branch of service
7. Sponsor's social security no.	12. Group name: **TRICARE Dental Program**
8. Patient mailing address (APO/FPO or street, city, country, postal mailing code)	13. Is patient covered by another dental plan? ☐ yes ☐ no — Dental plan name; Insured name and soc. sec. no.; Group no.; Name and address of carrier
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	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	21. Point of contact name (POC), telephone no., fax no., and email address			
16. Office address — City, country, postal mailing code	22. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
	23. Is treatment result of auto accident?			
16a. Billing address — City, country, postal mailing code	24. Other accident?			
	25. If prosthesis, is this initial placement?			(If no, reason for replacement) — 26. Date of prior placement
17. Dentist phone no. (including country, city, and/or area code) — 18. UCCI dentist no.	27. Is treatment for orthodontics?			Appliance insertion date — Total length of treatment **(Non-Availability and Referral Form Necessary) ***
19. Dentist fax no. — 20. Dentist email address	28. Transfer patient?			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.	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 any 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. I hereby certify that the procedures as indicated by date have been completed.

Signature (Dentist) — Date

32. TOTAL FEE CHARGED

33. INDICATE CURRENCY ☐ USD ☐ LOCAL

AMOUNT PAID

5678 B 7/00 **OCONUS**

Completing the TDP OCONUS Claim Form

AGENCY DISCLOSURE STATEMENT - 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. 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 OMB control number.
PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ADDRESS.
The completed form should be sent to United Concordia, TDP OCONUS Dental Unit, P.O. Box 69418, Harrisburg, PA 17106-9418 USA

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

- **Upper left corner** (Attending Dentist's Statement): 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 7. Sponsor's Social Security Number** (SSN). The sponsor's nine-digit SSN **must** appear on every claim form.
- **Box 8. Patient's 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 13. Is the patient covered by another dental insurance 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 14. 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 16. Dentist office address**. Include street, city, country, and postal mailing code where services were performed
- **Box 16A. Billing address**. Include street, city, country, and postal mailing code
- **Box 17. Dentist's phone number**. Include the country code and city code, along with local number.
- **Box 27. Treatment for Orthodontics**. For orthodontic care, submit a completed copy of this claim form along with a valid Non-Availability and Referral from and the provider's bill to the address on the front of this form.
- **Box 29. Examination and Treatment Plan**. Provide a detailed description of the services performed including applicable tooth numbers, dates of service, and fee charged.
- **Box 33. Currency**. Indicate type of currency billed to patient (US dollars or local currency)

General Instructions

- Submit a separate claim form for each 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.
- The family member must sign the appropriate sections of the claim form. If the family member is under 18 years of age, 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
- For non-orthodontic service, 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 for Active Duty Family Members in non-remote locations

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