ATTENDING DENTIST'S STATEMENT

Check One

☐ Dentist's pre-treatment estimate

☐ Dentist's statement of actual services

UNITED CONCORDIA
TRICARE Dental Program
Claims Processing
P.O. Box 69411
Harrisburg, PA 17106-9411

OMB NO. 0720-0035
EXPIRES:

PATIENT'S 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

City, State, Zip

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

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'S SECTION

15. Dentist name | 15a. Provider no.

16. Mailing address -- street address

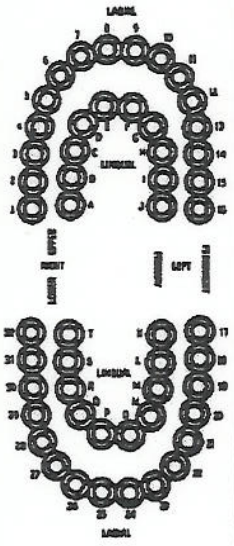
City, State, Zip

17. Dentist soc. sec. or T.I.N. | 18. Dentist license no. | 19. Dentist phone no.

20. First visit date current series | 21 Place of treatment: Office / Hosp. / ECF / Other | 22. Radiographs and/or documentation enclosed? No / Yes / How Many?

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

Identify missing teeth with "X"



31. Remarks for unusual services

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

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE CODE	FEE CHARGED	AMOUNT PAID

32. 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

33. TOTAL FEE CHARGED

34. PAYMENT OR COPAY OF OTHER PLAN

AMOUNT PAID

5578 D 7/00

Completing the TDP 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, TRICARE Dental Program, Claims Processing, P.O. Box 69411, Harrisburg, PA 17106-9411

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 and provider number**. The provider number represents the provider number assigned by United Concordia.
- **Box 16. Dentist address**. Include street, city, country, and postal mailing code.
- **Box 30. Examination and Treatment Plan**. Provide a detailed description of the services performed including applicable tooth numbers, dates of service, and fee charged.

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 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 dentist must sign the appropriate sections of the claim form.