UNITED CONCORDIA
Claims Processing
P.O. Box 69457
Harrisburg, PA 17106-9429

DENTIST'S CLAIM FORM

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

OMB Control Number: 0720-0053
Expiration: 3/31/2026

PATIENT SECTION

1. Sex ◯ Male ◯ Female

2. Birthdate Mo Day Year

3. Active Duty Service Member's (ADSM's) name
First Middle Last

7. Program name
TRICARE Active Duty Dental Program

4. ADSM's social security number or DoD Benefits Number (DBN).

8. Appointment Control Number

5. ADSM's mailing address (APO/FPO or street, city, country, postal mailing code)

Authorization Number or Referral Number

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

6. Telephone number (include country, city, and/or area code)

Signature Date

DENTIST SECTION

10. Treating facility (name of practice) 10a. Treating doctor(name of dentist) 10b. Treating dentist's license #, issue date/expiration date, if applicable

11. Address, Phone # and Email address 12. City, postal mailing code 13. Country

14. Dental Readiness Classification (DRC): ____

☐ (1) ADSM has good oral health and is not expected to require dental treatment or reevaluation for 12 months.

☐ (2) ADSM has some oral conditions, but you **do not** expect these conditions to result in dental emergencies within 12 months if not treated (i.e., requires prophylaxis,, carries a symptomatic with minimal extension into dentin, edentulous areas not requiring immediate prosthetic treatment).

☐ (3) ADSM has oral conditions that you **do** expect to result in dental emergencies within 12 months if not treated. Examples of conditions are: *(X the applicable block or specify in the space provided)*

- ☐ (a) **Infections:** Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
- ☐ (b) **Caries/Restorations:** Dental caries or fractures with moderate or advanced extension into dentin; defective restorations or temporary restorations that patients cannot maintain for 12 months.
- ☐ (c) **Missing Teeth:** Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.
- ☐ (d) **Periodontal Conditions:** Acute gingivitis or pericoronitis, active moderate to advanced periodontitis, periodontal abscess, progressive mucogingival condition, moderate to heavy subgingival calculus, or periodontal manifestations of systemic disease or hormonal disturbances.
- ☐ (e) **Oral Surgery:** Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
- ☐ (f) **Other:** Temporomandibular disorders or myofascial pain dysfunction requiring active treatment.

15. If you selected DRC block 3 above, briefly describe the condition(s) below. This block should be used to provide clinical narratives for required procedures.

16. Please choose a date format for the date of service performed: ◯ 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

17. 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

18. Pay Member ◯ Pay Dentist ◯

19. TOTAL FEE CHARGED

20. INDICATE CURRENCY ◯ USD ◯ LOCAL Currency Type

21. AMOUNT PAID BY MEMBER

Completing the ADDP OCONUS Claim Form

The completed form should be sent to:
United Concordia, ADDP OCONUS Dental Unit, P.O. Box 69457, Harrisburg, PA 17106-9452

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

- ☐ **Box 4. Active Duty Service Member's (ADSM) Social Security Number (SSN) or DoD Benefits Number (DBN).** The ADSM's nine-digit SSN or 11-digiit DBN must appear on every claim form.

- ☐ **Box 5. 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 9. Release of information.**

- ☐ **Box 10. Dentist Name, provider number and license number.** The provider number represents the provider number assigned by United Concordia.

- ☐ **Box 11-13. Dentist Address, Email and Phone number.** Include the country code and city code, along with local number.

- ☐ **Box 14. Dental Readiness Classification (DRC).** The individual you are examining is an Active Duty Service Member of the United States Uniformed Forces. This ADSM needs your assessment of his/her dental health for worldwide duty. Please mark (X) in the field, that best describe the condition of the ADSM, using as a suggested minimum a clinical examination with mirror and probe, and bitewing radiographs. This form is meant to determine fitness for prolonged duty without ready access to dental care and is not intended to address the ADSM's comprehensive dental needs.

- ☐ **Box 15. DRC Block 3 condition explanation or Clinical Narrative requirement.** Please briefly describe condition if block 3 for Dental Readiness Classification was selected. This block should also be used to provide a clinical narrative for required procedures.

- ☐ **Examination and treatment plan.** Provide a detailed description of the services performed including applicable tooth numbers, dates of service, and fee charged.

- ☐ **Box 20. Indicate Currency: Indicate type of currency billed** (U.S. dollars or local).

General Instructions

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 ADSM must sign the appropriate sections of the claim form.
- The dentist must sign the appropriate sections of the claim form.