

DENTIST'S CLAIM FORM

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

Form Approved OMB
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1. Sex Male Female	2. Birthdate Mo Day Year
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3. Active Duty Service Member's (ADSM's) name First Middle Last
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4. ADSM's social security number or DoD Benefits Number (DBN).
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5. ADSM's mailing address (APO/FPO or street, city, country, postal mailing code)

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

10. Treating facility (name of practice)
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10a. Treating doctor(name of dentist)

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

13. Country

14. Dental Readiness Classification (DRC): ____

<input type="checkbox"/> (1) ADSM has good oral health and is not expected to require dental treatment or reevaluation for 12 months.

<input type="checkbox"/> (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).

<input type="checkbox"/> (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)
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<input type="checkbox"/> (a) Infections: Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.

<input type="checkbox"/> (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.
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<input type="checkbox"/> (c) Missing Teeth: Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.

<input type="checkbox"/> (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.
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<input type="checkbox"/> (e) Oral Surgery: Unerrupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.

<input type="checkbox"/> (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:
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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

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7. Program name TRICARE Active Duty Dental Program
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8. Appointment Control Number

Authorization Number or Referral Number

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

Signature

Date

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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 Currency Type
LOCAL

21. AMOUNT PAID
BY MEMBER

Completing the ADDP 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, 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-digit 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.