TRICARE ACTIVE DUTY DENTAL PROGRAM

UNITED CONCORDIA®

Authorization Request

Fields with asterisks (*) are required

Date: _____

*Provider Point of Contact Name: _____ Provider Point of Contact Phone: _____

*Provider Name: _____ Provider Point of Contact Email: _____

*Provider ID: _____

Are multiple appointments required to complete treatment? Yes No

Referred Services** (Please enter at least one service line and include either tooth number ***or tooth range.)

Procedure Code: _____ Tooth Number _____ Tooth Range _____

Tooth Surface(s) _____ Charge _____

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Tooth Surface(s) _____ Charge _____

Attachments? Yes No

Notes:

Appointment Information

*Social Security Number: _____ *Member Name: _____

*Date of Birth: _____ *Member Rank: _____

*Member Branch of Service: _____

*Member Address: _____

_____

Member Email: _____ Member Phone: _____ *Either email or phone is required*

Member Fax: _____ Contact Preference: _____

First Appointment Date & Time: _____ a.m. p.m.

Authorizations are sent to the Dental Service Point of Contacts (DSPOCs) for review determination within 4-6 business days of receipt. All requests for authorization must be submitted with the required diagnostic materials. Radiographs must be of clinical diagnostic quality and clearly indicate the patient's name and the date the radiograph was taken. For a complete list of diagnostic material requirements, please visit our website at https://secure.addp-ucci.com/ddpddw/dentists/diag-mat-requirements.xhtml. Incomplete authorization requests will not be forwarded for DSPOC review.

Return to United Concordia by mailing

United Concordia Companies, Inc. • ADDP Case Management • P.O. Box 69431 • Harrisburg, PA 17106-9431