TRICARE ACTIVE DUTY DENTAL PROGRAM

UNITED CONCORDIA

Referral Request

Fields with asterisks (*) are required

Date: _____ *DTF Point of Contact Name: _____

*Dental Treatment Facility Name/Number: _____

*DTF Point of Contact Email: _____ DTF Point of Contact Phone: _____

*Requesting Military Dentist's Name: _____ DTF Point of Contact Fax: _____

*Current Dental Readiness Classificiation: (Circle one) 3 - Not Deployable 2 - Deployable 1 - Deployable

*Expected Dental Readiness Classificiation: (Circle one) 3 - Not Deployable 2 - Deployable 1 - Deployable

Oral Health Care Initiative: (Circle one) Yes No

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

Procedure: _____ Tooth Number _____ Tooth Range _____ Tooth Surfaces _____

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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: _____

*Who will be responsible for scheduling the appointment? (Circle one) United Concordia Service Member

If you have a provider preference, please enter the information below:

Provider Name: _____ Specialist: Yes No

Provider Address: _____

_____

Provider Phone: _____ Provider Fax: _____

For United Concordia use only

Referral Number _____ Appointment Control Number _____

Return to United Concordia by faxing: 1-866-308-4138
or mailing: United Concordia Companies, Inc. • ADDP Unit • P.O. Box 69430 • Harrisburg, PA 17106-9430