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

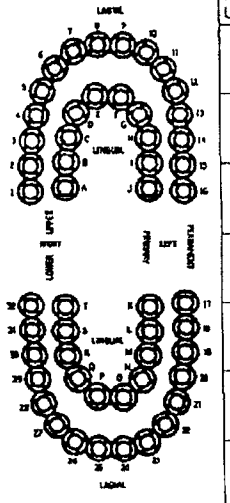
Harrisburg, PA 17106-9411

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
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

15. Dentist name / 15a. Provider no.	23. Is treatment result of occupational illness or injury?	No ☐	Yes ☐ If yes, enter brief description and dates
16. Mailing address -- street address City, State, Zip	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
17. Dentist soc. sec. or T.I.N. / 18. Dentist license no. / 19. Dentist phone no.	28. Is treatment for orthodontics?	☐	☐ Appliance insertion date / Total length of treatment
20. First visit date current series / 21. Place of treatment: Office / Hosp. / ECF / Other	22. Radiographs and/or documentation enclosed? No ☐ Yes ☐ How Many?	29. Transfer patient? ☐	☐ If yes, reband date / If no, starting date of treatment
		Was patient rebanded? ☐	☐

Identify missing teeth with "X"



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

31. Remarks for unusual services

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	AMOUNT PAID
34. PAYMENT OR COPAY OF OTHER PLAN	