DELTA DENTAL®

SEND DOMESTIC CLAIMS TO:
Federal Government Programs
Po Box 537007
Sacramento, CA 95853-7007

SEND OVERSEAS CLAIMS TO:
Federal Government Programs
Po Box 537006
Sacramento, CA 95853-7006
United State of America

TRICARE Retiree Dental Program
Claim Form

1
☐ STATEMENT OF COMPLETED SERVICES ☐ PRE-TREATMENT ESTIMATE

Other coverage

2 IS PATIENT COVERED BY ANOTHER DENTAL/MEDICAL PLAN?
☐ NO (SKIP 3-9) ☐ YES

3 NAME OF EMPLOYEE/POLICYHOLDER (LAST, FIRST, MI)

4 DATE OF BIRTH (MM/DD/YYYY) | 5 GENDER ☐ M ☐ F | 6 EMPLOYEE SSN/ID#

7 RELATIONSHIP TO PATIENT
☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER

8A GROUP NUMBER OF OTHER CARRIER | 8B AMOUNT PAID GROUP BY OTHER CARRIER $

9 NAME AND ADDRESS OF OTHER CARRIER

Subscriber information

10 NAME (LAST, FIRST, MI) AND ADDRESS

11 PHONE NUMBER (INCLUDING COUNTRY, CITY AND/OR AREA CODE) | 12 EMAIL ADDRESS

13 DATE OF BIRTH (MM/DD/YYYY) | 14 GENDER ☐ M ☐ F

15 SUBSCRIBER IDENTIFICATION NUMBER

Patient information

16 PATIENT NAME (LAST, FIRST, MI) AND ADDRESS (IF DIFFERENT THAN PRIMARY ENROLLEE)

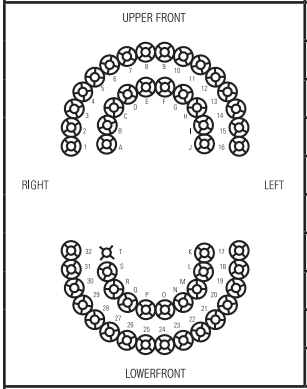
17 DATE OF BIRTH (MM/DD/YYYY) | 18 IF FULL-TIME STUDENT, LIST SCHOOL AND CITY

19 RELATIONSHIP TO SUBSCRIBER
☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER

20 GENDER ☐ M ☐ F

Dental services

21 TREATMENT PLAN (LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32) USING THE CHARTING SYSTEM SHOWN BELOW



TOOTH GUIDE		TOOTH NUMBER OR LETTER	TOOTH SURFACE	DESCRIPTION	DATE OF SERVICE (MM/DD/YYYY)	CDT PROCEDURE CODE	FEE CHARGED
	1						
	2						
	3						
	4						
	5						
	6						
	7						
	8						
	9						
	10						

22 INDICATE CURRENCY | TOTAL FEES CHARGED $0.00

23 REMARKS FOR UNUSUAL SERVICES

IMPORTANT: FOR OVERSEAS CLAIMS, ATTACH THE DENTIST'S RECEIPT FOR COMPLETED SERVICES OR STATEMENT FOR A PRE-TREATMENT ESTIMATE.

Authorizations

24

I HAVE REVIEWED THE TREATMENT PLAN AND AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES NOT PAID BY MY DENTAL BENEFIT PLAN UNLESS THE TREATING DENTIST HAS A CONTRACTUAL AGREEMENT WITH MY PLAN PROHIBITING ALL OR A PORTION OF SUCH CHARGES. I CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

X _____
SIGNATURE OF PATIENT (OR PARENT/GUARDIAN) DATE

25

I HEREBY AUTHORIZE AND DIRECT PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME, DIRECTLY TO THE NAMED DENTIST OR DENTAL ENTITY.

X _____
SIGNAURE OF PRIMARY ENROLLEE DATE

Billing dentist or dental entity

LEAVE THIS SECTION BLANK IF DENTIST OR DENTAL ENTITY IS NOT SUBMITTING THIS CLAIM

26 DENTIST OR DENTAL ENTITY NAME AND ADDRESS

27 TIN | 28 TYPE-2 NPI (ORGANIZATIONAL)

Treating dentist

29 DENTIST NAME AND ADDRESS

30 LICENSE NUMBER | 31 TIN OR SSN | 32 TYPE-1 NPI (INDIVIDUAL)

33

I HEREBY CERTIFY THAT THE PROCEDURES LISTED BY DATE ARE IN PROGRESS (FOR PROCEDURES THAT REQUIRE MULTIPLE VISITS) OR HAVE BEEN COMPLETED.

X _____
SIGNATURE OF DENTIST DATE

Additional claim information

34 RADIOGRAPHS ENCLOSED ☐ NO ☐ YES

35 REPLACEMENT OF PROSTHESIS ☐ YES DATE OF PRIOR PLACEMENT _____

36 TREATMENT RESULTING FROM
☐ OCCUPATIONAL ILLNESS/INJURY ☐ AUTO ACCIDENT ☐ OTHER ACCIDENT

DATE _____

37 TREATMENT RELATED TO ORTHODONTICS
☐ YES DATE APPLIANCE PLACED _____ TOTAL MONTHS OF TREATMENT _____