Completing the TRDP Enhanced-Overseas Claim Form

Most of the TRDP Enhanced-Overseas Claim Form is self-explanatory; however, there are certain fields to which special attention should be paid to ensure correct processing:

- **BOX 1.** Service Type: Check the appropriate box to indicate if your claim is for services completed or for a predetermination (estimate) of services to be performed. The dentist's original receipt for completed services or statement for predetermination of services must be attached to the Enhanced-Overseas Claim Form.
- **BOX 2.** Is patient covered by another dental/medical plan?: Check "No" if the family member has no other dental coverage and skip to box 10. If the family member has other dental coverage, please check "Yes" and complete boxes 3 through 9 to include the complete name, date of birth, gender and Social Security number of the insured ("employee/policyholder"); and group number, amount paid by, and complete name and address of the other insurance plan ("other carrier").
- **BOX 10 - 13.** Primary enrollee name (last, first, mi) and address, date of birth (mm/dd/yyyy), phone number (including country, city and/or area code, e-mail address: Be sure to provide the full name (no nicknames, please) and current, complete mailing address of the primary enrollee to include APO/FPO and/or street, city, country, postal mailing code. Please include a phone number (with country code and city code) and/or an e-mail address so that Delta Dental can contact you with any questions.
- **BOX 15.** Retiree social security number: The sponsor's ("retiree's") nine-digit SSN is required on each Enhanced-Overseas Claim Form submitted.
- **BOX 16 - 17.** Patient name (last, first mi), date of birth (mm/dd/yyyy): List patient's full name (no nicknames, please).
- **BOX 20.** Relationship to primary enrollee: Check the appropriate box.
- **BOX 21.** Signature of patient (or parent/guardian), date: The patient must sign and date the appropriate section of the Enhanced-Overseas Claim Form. If the patient is under 18 years of age, the parent or guardian must sign and date the form.
- **BOX 22.** Treatment plan: Provide detailed information about the services performed, including applicable tooth number/letter and surface, date the service was completed, description of the service provided, appropriate CDT procedure code that corresponds to the service provided, when possible and the fee charged in local currency or U.S. dollars.
- **BOX 25.** Indicate currency: Indicate the type of currency billed to patient (local currency or U.S. dollars). Delta Dental will convert local currency to U.S. dollars based on the date of service (please do not make the conversion yourself) and will make any applicable reimbursement directly to the enrollee in U.S. dollars based on the date of service.
- **BOX 26.** Dentist name: Please provide the dentist's full name.
- **BOX 28 – 31.** Office address, phone number (including country, city and/or area code), fax number (including country, city and/or area code), e-mail address: Include the street, city, country and postal mailing code where the services were performed and the dentist's phone number (with country code and city code) and/or e-mail address so that Delta Dental can contact the dentist with any questions.
- **BOX 32 – 35.** Complete applicable boxes for any additional information required to process this claim. If all necessary information is not included, your claim may be denied.

General Instructions

- Submit a separate claim form for each family member who receives treatment.
- All Enhanced-Overseas Claim Forms for TRDP covered services should be completed and submitted to Delta Dental as soon as possible after the service is provided. Claims must be received by Delta Dental within 12 months of the date of service in order to be processed. Claims received on or after the first day of the month following 12 months of the date of service will be denied.
- For Delta Dental to process your Enhanced-Overseas Claim Form, it must be filled out completely and correctly and must be signed by the patient (or parent/guardian) and the dentist who provided the services.
- The dentist's receipt for completed services or a statement of predetermined services must be attached for processing.
- Refer to your TRDP Enhanced Program Benefits Booklet and Enhanced-Overseas Program supplement for more information on all covered services as well as detailed information on benefit levels, limitations, exclusions, and overseas claims processing and reimbursement policies.
- Submit completed TRDP Enhanced-Overseas Claim Forms and all required attachments to: Delta Dental of California, PO Box 537006, Sacramento, California 95853-7006, United States of America.

The Enhanced-Overseas TRICARE Retiree Dental Program

A supplemental guide to the Enhanced TRDP for enrollees living overseas

Effective October 1, 2008, retired Uniformed Service members and their families who reside permanently overseas are eligible to enroll in the **Enhanced-Overseas TRICARE Retiree Dental Program (TRDP)** for access to their program benefits anywhere in the world. All covered benefits, policies, limitations and exclusions of the Enhanced TRDP as outlined in the Enhanced Program Benefits Booklet apply to enrollees in the Enhanced-Overseas TRDP except where noted in this supplement.

Group Name and Number

Enrollees in the Enhanced TRDP whose permanent residence is outside the 50 United States, the District of Columbia, Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands and Canada are considered to be enrolled in the **Enhanced-Overseas TRDP**. The group number for the Enhanced-Overseas TRDP is 4602.

Service Area

The service area for enrollees in the Enhanced-Overseas TRDP is worldwide. This includes the 50 United States, the District of Columbia, Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands, and Canada as well as all other countries, provinces, territories and/or districts outside this area.

Eligibility

Applicants for the Enhanced-Overseas TRDP must meet the eligibility requirements for enrollment in the Enhanced TRDP and must reside permanently outside the 50 United States, the District of Columbia, Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands, and Canada.

Premiums

Premium rates for enrollees in the Enhanced-Overseas Program are based on the enrollment option selected (i.e., single enrollment, two-person enrollment, or family enrollment of three or more persons) and are subject to adjustment on October 1 of each contract year. Current premium rates for enrollees in the Enhanced-Overseas TRDP are available on the web site at www.trdp.org or by contacting Delta Dental at the number(s) listed in this supplement. Premium payments are accepted in U.S. dollars only.

Dentists

Enrollees in the Enhanced-Overseas TRDP have access to an international list of dentists. Through Delta Dental's international referral service, Enhanced-Overseas TRDP enrollees can search for dentists and dental clinics in virtually every country in the world.

To locate an overseas dentist, enrollees may call the international referral service toll-free from inside the U.S. at 888-558-2705, or collect from anywhere in the world at 312-356-5971. Multi-lingual assistance coordinators are available 24 hours a day, 365 days a year to help you find a dentist overseas. When calling collect from outside the U.S., you must first dial the international dialing code from the country in which you are located and then the country code for the U.S. ("1"); be sure to tell the assistance coordinator that Delta Dental is your dental coverage carrier, and specify the city and country in which you are looking for a dentist. (Enrollees in the Enhanced-Overseas TRDP should note that these dentists are not contracted or otherwise affiliated with Delta Dental.)

Enhanced-Overseas TRDP enrollees may also select a dentist from the overseas host nation provider search tool for their overseas dental care. This list of overseas host nation providers, available on the TRDP web site at www.trdp.org, will be updated regularly, so enrollees seeking dental care overseas should check the web site frequently for the most current list of available dentists.

Note: This directory of Host Nation Providers servicing the TRICARE Retiree Dental Program is provided to you for your information. The listed dentists are not Delta Dental network dentists but have been found to have met certain minimum standards established by the U.S. Department of Defense. Inclusion on this list does not constitute an endorsement by the U.S. Government or by Delta Dental of California, its agents or subcontractors, nor does it constitute any representation or warranty as to the credentials or quality of care rendered by any listed dentist.

Claims submission and payment

For services provided by an overseas dentist, Enhanced-Overseas TRDP enrollees will need to pay in full at the time of service and should obtain a detailed receipt. To be reimbursed, enrollees must submit their claims directly to Delta Dental and include the dentist's full name, address (including city and country), phone number and/or e-mail address, services performed and a list of the teeth treated. Delta Dental will convert the fees to U.S. dollars and make payment directly to the enrollee in U.S. dollars based on the date of service. Enhanced TRDP benefits are not assignable to dentists overseas.

Enrollees can download and print an Enhanced-Overseas TRDP claim form from the TRDP web site at www.trdp.org. A blank claim form that can be photocopied is also included with this supplement. The claim form must be completed, signed and submitted, along with the detailed original receipt obtained from the dentist, to Delta Dental at the following address:

Delta Dental of California
Federal Services Division
PO Box 537006
Sacramento, CA 95853-7006
United States of America

The claim form should include the enrollee's/patient's current address and phone number and/or e-mail address so Delta Dental can contact you with any questions.

Contact Information

Telephone Inquiries (International Toll-Free):
(AT&T USADirect Access Number*) + 866-721-8737
24 hours a day, 7 days a week
For assistance with international dialing instructions, please visit www.usa.att.com/traveler/index.jsp

Written Inquiries:
Delta Dental of California
Federal Services
PO Box 537008
Sacramento, CA 95853-7008
United States of America

Online Inquiries:
www.trdp.org

Claims Submission:
Delta Dental of California
Federal Services
PO Box 537006
Sacramento, CA 95853-7006
United States of America

TRDP Web Site:
www.trdp.org

TRDP MM037 08/09
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FEDERAL SERVICES
PO BOX 537006
SACRAMENTO, CA 95853-7006
UNITED STATES OF AMERICA

TRICARE Retiree Dental Program
Enhanced-Overseas Claim Form

Service type

1 ☐ COMPLETED SERVICES ☐ STATEMENT OF PRE-DETERMINATION

IMPORTANT: ATTACH TO THIS FORM THE DENTIST'S RECEIPT FOR COMPLETED SERVICES OR STATEMENT FOR PRE-DETERMINATION.

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

Primary enrollee information

10 PRIMARY ENROLLEE NAME (LAST, FIRST, MI) AND ADDRESS

11 DATE OF BIRTH (MM/DD/YYYY) | 12 PHONE NUMBER (INCLUDING COUNTRY, CITY AND/OR AREA CODE)

13 E-MAIL ADDRESS | 14 GENDER ☐ M ☐ F

15 RETIREE SOCIAL SECURITY NUMBER

Patient information

16 PATIENT NAME (LAST, FIRST, MI)

17 DATE OF BIRTH (MM/DD/YYYY) | 18 GENDER ☐ M ☐ F | 19 IF FULL-TIME STUDENT, LIST SCHOOL AND CITY

20 RELATIONSHIP TO PRIMARY ENROLLEE
☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER

21

I HAVE REVIEWED THE TREATMENT PLAN AND AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES NOT PAID BY MY DENTAL BENEFIT PLAN. 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

Dental services

22 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
UPPER FRONT	1						
	2						
	3						
	4						
RIGHT LEFT	5						
	6						
	7						
	8						
	9						
LOWER FRONT	10						

23 REMARKS FOR UNUSUAL SERVICES

24 TOTAL FEES CHARGED $

25 INDICATE CURRENCY

Dentist information

26 DENTIST NAME | 27 DENTIST NUMBER

28 OFFICE ADDRESS

29 PHONE NUMBER (INCLUDING COUNTRY, CITY AND/OR AREA CODE)

30 FAX NUMBER (INCLUDING COUNTRY, CITY AND/OR AREA CODE)

31 E-MAIL ADDRESS

Additional claim information

32 NUMBER OF RADIOGRAPHS ENCLOSED | 33 REPLACEMENT OF PROSTHESIS ☐ YES DATE OF PRIOR PLACEMENT

34 TREATMENT RESULTING FROM
☐ OCCUPATIONAL ILLNESS/INJURY ☐ AUTO ACCIDENT ☐ OTHER ACCIDENT ____________

DATE ____________

35 TREATMENT RELATED TO ORTHODONTICS
☐ YES DATE APPLIANCE PLACED ____________ TOTAL MONTHS OF TREATMENT ____________

36

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR FALSE, INCOMPLETE, OR MISLEADING INFORMATION, OR WHO CONCEALS, FOR THE PURPOSE OF MISLEADING, ANY 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 LISTED BY DATE ARE IN PROGRESS (FOR PROCEDURES THAT REQUIRE MULTIPLE VISITS) OR HAVE BEEN COMPLETED.

X
SIGNATURE OF DENTIST DATE

TRDP MM0550s 06/08