



FEDERAL SERVICES
PO BOX 537007
SACRAMENTO, CA 95853-7007

TRICARE Retiree Dental Program Claim Form

1 STATEMENT OF COMPLETED SERVICES PRE-DETERMINATION REQUEST

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 NAME (LAST, FIRST, MI) AND ADDRESS

11 DATE OF BIRTH (MM/DD/YYYY) 12 GENDER M F

13 RETIREE SOCIAL SECURITY NUMBER

Patient information

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

15 DATE OF BIRTH (MM/DD/YYYY) 16 IF FULL-TIME STUDENT, LIST SCHOOL AND CITY

17 RELATIONSHIP TO PRIMARY ENROLLEE
 SELF SPOUSE DEPENDENT OTHER 18 GENDER M F

Dental services

19 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 | | | | | |
| TOTAL FEES CHARGED \$ | | | | | | | |

20 REMARKS FOR UNUSUAL SERVICES

Authorizations

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 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 _____ DATE

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)

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

X _____ DATE

SIGNATURE OF PRIMARY ENROLLEE

Treating dentist

26 DENTIST NAME AND ADDRESS

27 LICENSE NUMBER 28 TIN OR SSN 29 TYPE-1 NPI (INDIVIDUAL)

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

X _____ DATE

SIGNATURE OF DENTIST

Billing dentist or dental entity

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

23 DENTIST OR DENTAL ENTITY NAME AND ADDRESS

24 TIN 25 TYPE-2 NPI (ORGANIZATIONAL)

Additional claim information

31 RADIOGRAPHS ENCLOSED
 NO YES

32 REPLACEMENT OF PROSTHESIS
 YES DATE OF PRIOR PLACEMENT _____

33 TREATMENT RESULTING FROM
 OCCUPATIONAL ILLNESS/INJURY AUTO ACCIDENT OTHER ACCIDENT
DATE _____

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