



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 \_\_\_\_\_ DATE

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)

**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
	1					
	2					
	3					
	4					
	5					
	6					
	7					
	8					
	9					
	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 \_\_\_\_\_ DATE

SIGNATURE OF DENTIST

# 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.