UNITED CONCORDIA Claims Processing P.O. Box 69457 Harrisburg, PA 17106-9429

Form Approved OMB No. Expires



A	. Sex	☐ Male	☐ Fema			2. Birthdat	e mo	day	year			Expire	s	THE WINDS	
E	Active Duty Service Member's (ADSM's) name First Middle Last										7. Program name TRICARE Active Duty Dental Program				
T 4.	. ADSM's s	ocial secu	rity numb	er or De	ntal Benefits Num	ber (DBN).		8. Appointment Control Number							
S 5.	5. ADSM's mailing address (APO/FPO or street, city, country, postal mailing code)										Authorization Number or Referral Number				
1												ewed the follow lating to this cla		uthorize release of any	
0 N	i. Telephon	e number	(include d	country, c	city, and/or area o	ode)					Signature			Date	
1	10. Dentist i	name			10a. Pr	ovider no.	10b. Lic	ense #			12. Dentist m	nailing address	street address		
D 1 E N 1	11. Dentist Email Address										City, country, postal mailing code				
T	11a. Dentist	t phone no	(include	country	code/area code)										
S T	13. Dental F	Readiness	Classifica	ation (DR	C):										
S E C T P	(2) ADSN caries (3) ADSN provided) (a) In	M has som s with mini M has oral	ne oral co mal exter condition Acute or	nditions, nsion into ns that you	o dentin, edentulo ou <u>do</u> expect to re- ons, pulpal or peri	spect these con us areas not re- sult in dental er apical patholog	nditions to requiring immergencies	esult in de nediate pro within 12 oral infect	ental emerger osthetic treat months if no ions, or other	ncies with tment). It treated.	Examples of o	conditions are:	e., requires prophylax (X the applicable block or ng biopsy or awaiting le restorations that patie	specify in the space	
O N	` n	naintain fo	r 12 mon	ths.									·	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	. ,	-			reas requiring imr ute gingivitis or pe									on, moderate to heavy	
					odontal manifesta						ns or symptor	ms of nathosis	that are recommended	d for removal	
	. ,	_	-		isorders or myofa						no or cymptor	no or patrioolo	mat are recommende	a for formoval.	
	4. If you selection					ondition(s) you i	identified ir	n this ADS	M if they app	ear above	e, or briefly de	scribe the cond	lition(s) below. This b	lock should be used to	
	icate tooth			5. Examir	nation and treatme	ent plan—list in	order from	Tooth No	. 1 through T	ooth No.	32—Use char	ting system sho	own.		
101	provid			TOOTH NO. OR LETTER	SURFACE				RVICES .AXIS, MATEI	RIALS	Р	DATE SERVICE ERFORMED	PROCEDURI CODE	FEE CHARGED	
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that t		ures as ind			ve been complete			Da	•		, ,	19. INDICAT	TE CURRENCY		
		,										USD	LOCAL		

Completing the ADDP OCONUS Claim Form

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid Office of Management and Budget (OMB) control number. Please do not return your response to the above address. Responses should be sent to the address provided below.

The completed form should be sent to:
United Concordia, ADDP OCONUS Dental Unit, P.O. Box 69457, Harrisburg, PA 17106-9452

Мо	st of the ADDP Claim form is self-explanatory; however, there are certain fields to which special attention should be paid.
	Box 4. Active Duty Service Member's (ADSM) Social Security Number (SSN) or Dental Benefits Number (DBN). The ADSM's nine-digit SSN or 11-digiit DBN must appear on every claim form.
	Box 5. Mailing Address . Be sure to provide the current and complete mailing address to include APO/FPO and/or street, city, country, and postal mailing code.
	Box 9. Release of information.
	Box 10. Dentist Name, provider number and license number. The provider number represents the provider number assigned by United Concordia.
	Box 11. Dentist Email and Phone number. Include the country code and city code, along with local number.
	Box 12. Dentist address. Include street, city, country, and postal mailing code.
	Box 13. Dental Readiness Classification (DRC). The individual you are examining is an Active Duty Service Member of the United States Uniformed Forces. This ADSM needs your assessment of his/her dental health for worldwide duty. Please mark (X) in the field, that best describe the condition of the ADSM, using as a suggested minimum a clinical examination with mirror and probe, and bitewing radiographs. This form is meant to determine fitness for prolonged duty without ready access to dental care and is not intended to address the ADSM's comprehensive dental needs.
	Box 14. DRC Block 3 condition explanation or Clinical Narrative requirement. Please briefly describe condition if block 3 for Dental Readiness Classification was selected. This block should also be used to provide a clinical narrative for required procedures.
	Box 15. Examination and treatment plan. Provide a detailed description of the services performed including applicable tooth numbers, dates of service, and fee charged.
	Box 19. Indicate Currency: Indicate type of currency billed (U.S. dollars or local).
	Concret Instructions

General Instructions

All claim forms should be submitted to United Concordia as soon as possible after the service date, preferably within 60 days of the date of service. Claims postmarked more than 12 months after the date of service will be denied.

- The ADSM must sign the appropriate sections of the claim form.
- The dentist must sign the appropriate sections of the claim form.