UNITED CONCORDIA
Claims Processing
P.O. Box 69429
Harrisburg, PA 17106-9429

Web site: www.addp-ucci.com

Form Approved
OMB No. 0720-0053
Expires 12/31/2019

PATIENT SECTION

1. Sex ☐ Male ☐ Female

2. Birthdate mo day year

3. Active Duty Service Member's (ADSM) name
First middle last

4. Active Duty Service Member's (ADSM) social security no.

5. Mailing address

City, State, Zip

6. Telephone number

7. Rank/Branch of service

8. Program name
Active Duty Dental Program

9. Appointment Control Number

Authorization Number / Referral Number

10. Email Address

11. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signature Date

DENTIST SECTION

12. Dentist name 12a. Provider no. 12b. NPI #

13. Dentist soc. sec. or T.I.N. 14. Dentist license no. 15. Dentist phone no.

16. Dentist mailing address -- street address

City, State, Zip

Dental Readiness Class: _____

❑ (1) ADSM has good oral health and is not expected to require dental treatment or reevaluation for 12 months.

❑ (2) ADSM has some oral conditions, but you **do not** expect these conditions to result in dental emergencies within 12 months if not treated (i.e., requires prophylaxis,, asymptomatic caries with minimal extension into dentin, edentulous areas not requiring immediate prosthetic treatment).

❑ (3) ADSM has oral conditions that you **do** expect to result in dental emergencies within 12 months if not treated. Examples of conditions are: *(X the applicable block or specify in the space provided)*

- ❑ (a) **Infections:** Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
- ❑ (b) **Caries/Restorations:** Dental caries or fractures with moderate or advanced extension into dentin; defective restorations or temporary restorations that patients cannot maintain for 12 months.
- ❑ (c) **Missing Teeth:** Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.
- ❑ (d) **Periodontal Conditions:** Acute gingivitis or pericoronitis, active moderate to advanced periodontitis, periodontal abscess, progressive mucogingival condition, moderate to heavy subgingival calculus, or periodontal manifestations of systemic disease or hormonal disturbances.
- ❑ (e) **Oral Surgery:** Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
- ❑ (f) **Other:** Temporomandibular disorders or myofascial pain dysfunction requiring active treatment.

17. If you selected Block (3) above, please circle the condition(s) you identified in this ADSM if they appear above, or briefly describe the condition(s) below:

18.

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED,ETC.)	DATE SERVICE PERFORMED MO.	DAY	YR.	PROCEDURE CODE	FEE CHARGED

20. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, United Concordia may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practice.

19. TOTAL FEE CHARGED

Signature (Dentist) _____ Date _____

Completing the ADDP Claim Form

Most 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). The ADSM's nine-digit SSN **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 11. Release of information**.
- **Box 12. Dentist Name and provider number** - The provider number represents the provider number assigned by United Concordia.
- **Box 16. Dentist address.** Include street, city, country, and postal mailing code.
- **Box 17. Examination Results**. The individual you are examining is an Active Duty/Guard/Reserve member of the United States Uniformed Forces. This ADSM needs your assessment of his/her dental health for worldwide duty. **Please mark (X) the block** above this 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 18.** Provide a detailed description of the services performed including applicable tooth numbers, dates of service, and fee charged.

General Instructions

- Submit a separate claim form for each ADSM who receives treatment.
- 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.

AGENCY DISCLOSURE STATEMENT

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, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350-3100 (0720-0053). 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 OMB control number.

PLEASE DO NOT RETURN YOUR RESPONSE TO THE ABOVE ADDRESS.

Responses should be sent to:

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