DELTA DENTAL

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

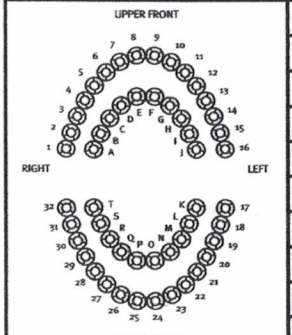
17 RELATIONSHIP TO PRIMARY ENROLLEE
☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER

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 _____
SIGNATURE OF PATIENT (OR PARENT/GUARDIAN) DATE

22

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

X _____
SIGNAURE OF PRIMARY ENROLLEE DATE

Treating dentist

26 DENTIST NAME AND ADDRESS
Scott H. Leaf, D.D.S.
9316-C Old Keene Mill Road
Burke, Virginia 22015

27 LICENSE NUMBER: 401005821

28 TIN OR SSN: 27-0773127

29 TYPE-1 NPI (INDIVIDUAL): 1346457983

30

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

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
Scott H. Leaf, D.D.S.
9316-C Old Keene Mill Road
Burke, Virginia 22015

24 TIN: 27-0773127

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 _____