UNITED CONCORDIA® DENTAL

Instructions for Completing Dental Claim Form

1. Completion of this form is only necessary if you visit **a non-network dentist**. Network dentists will complete and submit all necessary paperwork for you.

2. Please print clearly or type all required information.

3. **Patient Section:** The subscriber or spouse should complete the Patient Section of the form (Items 1 through 15) to assure positive identification and prompt payment.

4. **Patient Consent:** The patient consent statement is located below Item 15 on the form. If the patient is a minor, a parent must sign the statement. Other authorized representatives include caretaker, guardian or other individual as appropriate under state law and the circumstances of the case.

   By signing the statement, the patient (or parent or other authorized representative), consents to the use and disclosure of information relating to the services provided by the dentist or health care professional for the purpose of treatment, payment or health care operation, including submission of a claim for dental benefits to a provider or administrator of dental benefits.

5. **Assignment of Benefits:** The Assignment of Benefits statement is located to the right of the Patient Consent Statement on the claim form. If you wish United Concordia to make payment directly to the dentist, please sign and date this statement. If you wish benefits to be paid directly to yourself, do not sign the statement.

6. **Dentist Section:** Your dentist should complete Items 16 through 31 on the claim form; then sign and date the form. If your dentist does not agree to complete the Dentist Section, you need only to complete the following items on the claim form and *attach a copy of the bill* you receive from the dentist. This information will serve as proof that you were seen and had services performed by this dentist:

   Item 16: Dentist name
   Item 17: Dentist mailing address
   Item 20: Dentist office phone number

Please mail your completed Claim Form to:

Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421