UNITED CONCORDIA®

Act 396 Medication Substitution Reimbursement Request
(for participating Louisiana Oral Surgeons only)

COMPLETE THIS FORM AND RETURN BY MAIL OR FAX TO:	United Concordia Companies, Inc. Attn: Specialized Services Unit c/o Denise Thomas P.O. BOX 69414 Harrisburg, PA 17106 Fax: (866) 335-3974

DENTIST INFORMATION	
Dentist Name	United Concordia Provider ID
Office Phone Number	Office Address

PATIENT INFORMATION	
Patient Name	Subscriber ID Number
Health Insurer	Date of Service
Dental Insurer	

MEDICATION INFORMATION	
Were you contacted by Pharmacy Services regarding a replacement medication? ❑ Yes ❑ No	If yes, did you agree to the replacement medication? ❑ Yes ❑ No
Name of Prescribed Medication	Date of Prescription
Name of Replacement Medication	Date of Prescription Replacement Approval

TO BE COMPLETED BY DENTIST	
Print Full Name	Date
Signature	

If you have questions while completing this form, please contact us at (800) 307-8514.