



TRICARE Dental Program

Form to be used beginning February 1, 2006
 (Form also located at www.TRICAREdentalprogram.com)



NOTE: This form is only necessary for OCONUS **orthodontic and implant** care. In *Non-Remote Countries*, the sponsor/family member must forward this completed form to United Concordia with the completed claim form and the provider's bill for the claim to be processed. In *Remote Countries*, the sponsor or the location Point of Contact (POC) must forward this form to United Concordia along with a completed TDP OCONUS Claim Form and the provider's total bill. Additional information can be found in the TDP Benefit Booklet.

OCONUS NON-AVAILABILITY AND REFERRAL FORM (NARF)

PATIENT INFORMATION	1) PATIENT'S NAME LAST FIRST MI		2) DATE OF BIRTH MO DAY YEAR			3) SEX M F		4) RELATIONSHIP TO SPONSOR SPOUSE CHILD OTHER		
	5) SPONSOR'S NAME LAST FIRST MI		6) SPONSOR'S SOCIAL SECURITY NUMBER							
	7) PATIENT'S ADDRESS (APO/FPO or Street, City, Country, Postal Mailing Code)									
REFERRAL INFORMATION	8) REFERRING OVERSEAS DENTAL TREATMENT FACILITY/TRICARE AREA OFFICE (Name and Location)					9) PRIMARY REASON FOR REFERRAL: <input type="checkbox"/> a) Proper facilities or professional capability are temporarily not available at this facility. <input type="checkbox"/> b) Proper facilities or professional capability are permanently not available at this facility.				
	10) REFERRED SERVICE (Description of Service—include CDT code(s) if possible) Orthodontics: <input type="checkbox"/> <input type="checkbox"/> Diagnostic <input type="checkbox"/> Limited CDT Codes: <input type="checkbox"/> Extensive <input type="checkbox"/> Retainer					Implants: <input type="checkbox"/> CDT Codes:				
	11) REMARKS									
	12) NAME AND TITLE (Type or Print)									
SPONSOR/FAMILY MEMBER CERTIFICATION	13) APPROVAL SIGNATURE					14) DATE OF ISSUANCE *				
	* NOTE: FORM VALID FOR 120 DAYS FROM DATE OF ISSUANCE									
SPONSOR/FAMILY MEMBER CERTIFICATION	15) SPONSOR/FAMILY MEMBER CERTIFICATION I have confirmed my enrollment in the TDP. If I am not enrolled, I am responsible for the full cost of any dental care received. I confirm that, as of the date of this referral, I have not exceeded the appropriate lifetime orthodontic maximum. I understand that, if I have exceeded my maximum (\$1,500 for orthodontic services), I am responsible for the full cost of any additional orthodontic services received. I understand that, if I receive services for dental care not covered under this referral, I am responsible for the full cost of any dental care received outside the scope of this referral. SIGNATURE (Sponsor/Family Member) _____ DATE _____									
	16) I have received confirmation from the sponsor/family member that the above is true and that the sponsor/family member agrees to these certifications as of the date of this referral. INITIALS (Referring Party) _____ DATE _____					17) ODTF/TRICARE AREA OFFICE TRACKING NUMBER				

The information contained on this form is protected by the Privacy Act of 1974.

The quality of foreign provider care is not controlled by the Government or United Concordia or any of its agents or representatives. The fact that a foreign provider has been determined to provide acceptable dental care in the past does not guarantee acceptable future service. The Government's control over foreign providers is limited to their inclusion in or exclusion from the host nation provider list. Sponsors/family members should forward any complaints or concerns about foreign provider service quality of care to their respective TRICARE Area Office.

OCONUS ORTHODONTIC/IMPLANT NON-AVAILABILITY AND REFERRAL FORM (NARF) COMPLETION INSTRUCTIONS

Patient Information and Referral Information Fields must be completed by the servicing overseas dental treatment facility/TRICARE Area Office (TAO). Sponsor/Family Member Certification Fields must be completed by sponsor/enrollee. In the case of a family member under the age of 18, the parent or guardian must sign on their behalf. If the form is being faxed/mailed to a sponsor/family member, the Government representative completing the form must first explain the certifications to the sponsor/family member and initial/date this form where appropriate.

- 1) **Patient's Name:** Enter the last name, first name, and middle initial of the person being treated. Be sure to write the name as it appears on the uniformed services ID card.
- 2) **Date of Birth:** Enter the number of the month, day, and year of the family member's birth.
- 3) **Sex:** Check the appropriate box.
- 4) **Relationship to Sponsor:** Check the appropriate box.
- 5) **Sponsor's Name:** Enter the last name, first name, and middle initial of the sponsor, as it appears on the uniformed services ID card.
- 6) **Sponsor's Social Security Number:** Enter the sponsor's nine-digit Social Security number.
- 7) **Patient's Address:** Enter the home mailing address of the family member seeking dental treatment. Be sure to provide the complete address (Unit/PO Box/street, city, APO/FPO, country code, and postal mailing code).
- 8) **Referring Overseas Dental Treatment Facility/TRICARE Area Office:** Enter the name of the Overseas Dental Treatment Facility/TRICARE Area Office and the country where the referral will take place.
- 9) **Primary Reason for Referral:** Check the appropriate box.
- 10) **Referred Service:** Provide a detailed description of the service for which the patient is being referred. Ensure referrals are made for specific care and include the applicable CDT code(s), tooth number(s) and procedure name.
- 11) **Remarks:** Include any additional pertinent information. Include the provider's proposed orthodontic treatment plan. (If additional space is required, please continue on a separate sheet of paper.) Please provide treatment plans and progress notes in English.
- 12) **Name and Title:** Type or print the name and title of the person issuing the referral form.
- 13) **Approval Signature:** Enter the signature of the person issuing the referral form.
- 14) **Date of Issuance:** Enter the date the referral form is provided to the family member.
- 15) **Sponsor/Family Member Certification:** This area must be completed, signed, and dated by the sponsor/family member.
- 16) **Referring Party Confirmation:** If this form is being faxed/mailed to a sponsor/family member, the Government representative completing the form must initial and date the form **after** explaining the certification in **Field 15** to the sponsor/family member.
- 17) **ODTF/TRICARE Area Office Tracking Number:** For use by the Overseas Dental Treatment Facility/TRICARE Area Office.

Submit this Non-Availability and Referral Form, a completed TDP OCONUS Claim Form, and the provider's bill for total orthodontic or any implant services to the following address:

**United Concordia
TDP OCONUS Dental Unit
P.O. Box 69418
Harrisburg, PA 17106-9418
USA**

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