UNITED CONCORDIA®

HIPAA Privacy Release Form

The request for release of information is being made for the TDP enrollee identified below.

_____Effective Date

_____Sponsor SSN or DBN Number

_____Full Name of Individual Authorized to Release Information

_____Relationship to TDP Enrollee (Self, Legal Parent, Custodial Guardian)

_____Date of Birth

_____Phone

_____Email Address

_____Dependent Child's Full Name

_____Dependent Child's Full Name (optional)

_____Dependent Child's Full Name (optional)

_____Dependent Child's Full Name (optional)

Information that may be used or disclosed

- ☐ Claims Information
- ☐ Payment Information
- ☐ Patient Records
- ☐ Other Information _____

The information will be used for

- ☐ Obtaining Claims or Payment Information of resolution
- ☐ Other Usage

Persons/organizations authorized to receive the information

_____

_____

I understand that I may revoke this authorization at any time by sending a written notice of my revocation to:

United Concordia Companies, Inc.
TDP Customer Service
PO Box 69450
Harrisburg, PA 17106

I understand that revocation of this authorization will not affect any action UCCI or its subsidiaries, affiliates, business associates, etc. took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, UCCI may not use or disclose my health information for any reason except those described in UCCI's Notice of Privacy Policies and Practices. Unless otherwise revoked, this authorization will expire on the above date, event or circumstance. If no expiration is stated, this authorization will remain in effect indefinitely until revoked in writing.

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I release UCCI, its affiliated companies, employees, officers and business associates from legal liability for any recipient's use or disclosure of information released by UCCI in reliance on this authorization.

_____

Authorized signature of member or personal representative

Signature Date: _____

How to allow non-custodial parents to receive information

By completing the information on this form, you are authorizing United Concordia Companies, Inc. to release individual health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or by state law protecting the privacy of health information. This form should be used to allow spouses, non-custodial parents, etc. to receive information for the individuals indicated on this form. Authorization will remain in effect indefinitely, unless the authorization is revoked in writing.

UNITED CONCORDIA®

Fraud Complaint Form

United Concordia is committed to its members, the dental community and customers not to ignore fraud. Ignoring fraud results in higher insurance premiums.

Use this form if you suspect that fraudulent activity may have occurred.

Please provide as much information as possible pertaining to your complaint. Failure to provide sufficient information or documentation may prevent or delay the investigation of your complaint.

_____ Sponsor SSN or DBN

_____ Full Name of the person registering the complaint

_____ Email

_____ Address 1

_____ Address 2 (optional)

_____ City

_____ State

_____ ZIP Code

_____ Phone

_____ Relationship to the Patient (Patient, Authorized Representative, Other)

_____ Patient's Full Name

_____ Patient's Date of Birth

Dentist Information

_____ Name of Dentist (optional)

_____ Dentist Office

_____ Where's the Dentist located?

☐ Continental U.S ☐ Outside Continental U.S.

_____ Address 1

_____ Address 2 (optional)

_____ City

_____ State

_____ ZIP Code

_____ Phone

Has the patient been examined or treated by another dentist?

☐ Yes ☐ No

Fraud Complaint Details

*Please attach any relevant documentation when submitting this form.

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by the TRICARE Dental Program (TDP) and how it will be used.

AUTHORITY:	10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.13, TRICARE Dental Program; and E.O. 9397 (SSN), as amended.
PURPOSE:	To collect information from you to manage your enrollment in the TDP, administer your benefits, and pay for the services you receive.
ROUTINE USES:	Your records may be disclosed to providers of care and other business entities on matters relating to eligibility, claims pricing and payment, fraud, quality assurance, program integrity, and the coordination of benefits. Your records may also be disclosed outside of the Department of Defense (DoD) in accordance with the DoD Blanket Routine Uses published at Caution- http://dpcld.defense.gov/Privacy/SORNsIndex/Blanket-Routine-Uses/ and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.
DISCLOSURE:	Voluntary. If you choose not to provide this information, no penalty may be imposed, but absence of the requested information may delay or prevent your receipt of TDP services.