DO NOT WRITE IN THIS AREA

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
PO BOX 13189
SACRAMENTO, CALIFORNIA 95813-3189
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST, FIRST, M.I.)	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YR	5. MEDI-CAL BENEFITS ID CARD NUMBER
6. PATIENT ADDRESS			7. PATIENT DENTAL RECORD NUMBER
CITY, STATE ZIP CODE			8. REFERRING PROVIDER NPI

9. CHECK IF **RADIOGRAPHS ATTACHED?**	YES	11. CHECK IF **ACCIDENT/INJURY?**	YES	13. CHECK IF **OTHER DENTAL COVERAGE?**	YES	16. **CHDP CHILD HEALTH AND DISABILITY PREVENTION?** CHECK IF	YES
HOW MANY?		**EMPLOYMENT RELATED?**	YES	14. **MEDICARE DENTAL COVERAGE?**	YES	17. **CCS CALIFORNIA CHILDREN SERVICES?**	YES
10. **OTHER ATTACHMENTS?**	YES	12. **ELIGIBILITY PENDING?** (SEE PROVIDER HANDBOOK)	YES	15. **RETROACTIVE ELIGIBILITY?** (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK)	YES	18. **MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?**	YES

19. BILLING PROVIDER NAME (LAST, FIRST, M.I.)	20. BILLING PROVIDER NPI
21. MAILING ADDRESS	TELEPHONE NUMBER ( )
CITY, STATE	ZIP CODE

BIC Issue Date: _____

EVC #: _____

22. PLACE OF SERVICE
OFFICE 1 | HOME 2 | CLINIC 3 | SNF 4 | ICF 5 | HOSPITAL IN-PATIENT 6 | HOSPITAL OUT-PATIENT 7 | OTHER (PLEASE SPECIFY) 8

EXAMINATION AND TREATMENT

26. TOOTH #/LTR, ARCH, QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

34. COMMENTS	35. TOTAL FEE CHARGED	
	36. PATIENT SHARE-OF-COST AMOUNT	
	37. OTHER COVERAGE AMOUNT	
39. THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE.	38. DATE BILLED	

X _____ _____
SIGNATURE DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

IMPORTANT NOTE:
In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, **MUST** be attached to this form. The X-ray envelopes (DC-214A and DC-214B) are available free of charge from the Denti-Cal Forms Supplier.