

FFS & DMC: Carries Risk Assessment (CRA) Low Risk

DENTI-CAL
 CALIFORNIA MEDI-CAL DENTAL PROGRAM
 PO BOX 15610
 SACRAMENTO, CALIFORNIA 95852-0610
 Phone (800) 423-0507

**TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM**

1. PATIENT NAME (LAST, FIRST, MI) STRANGE, STEPHEN, V		3. SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. PATIENT BIRTHDATE MO 11 DAY 4 YR 14		5. MEDI-CAL BENEFITS ID CARD NUMBER 999999999A	
6. PATIENT ADDRESS 1111 ADDRESS WAY STREET						7. PATIENT DENTAL RECORD NUMBER	
CITY, STATE TULARE, CA				ZIP CODE 99999 - 9999		8. REFERRING PROVIDER NUMBER	
9. RADIOGRAPHS ATTACHED? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. ACCIDENT/INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		13. OTHER DENTAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOW MANY? _____		EMPLOYMENT RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO		14. MEDICARE DENTAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		17. CCS CALIFORNIA CHILDREN SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10. OTHER ATTACHMENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO		12. ELIGIBILITY PENDING? (SEE PROVIDER MANUAL) <input type="checkbox"/> YES <input type="checkbox"/> NO		15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL) <input type="checkbox"/> YES <input type="checkbox"/> NO		18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO	
19. BILLING PROVIDER NAME (LAST, FIRST, MI) SANCTUM SANTORUM CLINIC				20. BILLING PROVIDER NUMBER 1234567890			
21. MAILING ADDRESS 177A BLEEKER STREET				TELEPHONE NUMBER (999) 999-9999			
CITY, STATE TULARE, CA				ZIP CODE 99999-9999			
22. PLACE OF SERVICE OFFICE <input type="checkbox"/> HOME <input type="checkbox"/> CLINIC <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> HOSPITAL IN-PATIENT <input type="checkbox"/> HOSPITAL OUT-PATIENT <input type="checkbox"/> OTHER (PLEASE SPECIFY) _____ 1 2 3 4 5 6 7 8							
BIC Issue Date: _____							
EVC #: _____							
EXAMINATION AND TREATMENT							
26. TOOTH #/TR. ARCH, QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NO.
		1 CRIES RISK ASSESS – LOW	01/01/17	1	D0601	15.00	1234567890
		2 NUTRITIONAL COUNSELING	01/01/17	1	D1310	46.00	1234567890
		3 MOTIVATIONAL INTERVIEW	01/01/17	1	D9993	65.00	1234567890
		4 PROPHYLAXIS - CHILD	01/01/17	1	D1120	30.00	1234567890
		5 APPLICATION FLUROIDE	01/01/17	1	D1208	18.00	1234567890
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					
34. COMMENTS						35. TOTAL FEE CHARGED	174.00
						36. PATIENT SHARE-OF-COST AMOUNT	
						37. OTHER COVERAGE AMOUNT	
39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.						38. DATE BILLED	01/01/2017

X DENTIST SIGNATURE
 SIGNATURE

01/01/2017
 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 X-rays, if applicable, **MUST** be attached to this form. The X-ray envelopes (DC-014A and DC-014B) are available free of charge from the Denti-Cal Forms Supplier.

Instructions and Clarification

- CRA Procedures must be performed on the **same service date**, and claimed on the **same Treatment Authorization Request form**.

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		1 CRIES RISK ASSESS - LOW	07/01/17	1	D0601	15.00	1234567890
		2 NUTRITIONAL COUNSELING	07/01/17	1	D1310	46.00	1234567890
		3 MOTIVATIONAL INTERVIEW	07/01/17	1	D9993	65.00	1234567890
		4 PROPHYLAXIS - CHILD	07/01/17	1	D1120	30.00	1234567890
		5 APPLICATION FLUORIDE VARNISH	07/01/17	1	D1206	18.00	1234567890
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
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X DENTIST SIGNATURE
 SIGNATURE

DATE

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

Instructions and Clarification

- Beneficiaries who are categorized as **low risk** are **not eligible** for increased frequencies for procedures (D1120, D1206 or D1208, and D0120).
- Manual of Criteria (MOC) procedure frequencies apply.

IMPORTANT NOTE:

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