DO NOT WRITE IN THIS AREA

DHCS | Medi-Cal Dental
PO BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
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
LASTNAME, FIRST NAME M		02 / 02 / 1989	99999999A

6. PATIENT ADDRESS

CITY, STATE — ZIP CODE

7. PATIENT DENTAL RECORD NUMBER

8. REFERRING PROVIDER NPI

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

19. BILLING PROVIDER NAME (LAST, FIRST, M.I.): Dental Clinic

20. BILLING PROVIDER NPI: 9999999999

21. MAILING ADDRESS: 123 Any Street

TELEPHONE NUMBER: (999) 999-9999

CITY, STATE: Anytown, CA

ZIP CODE: 99999-9999

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	01/01/2022		D1320	$7.50	9999999999
		2					
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		10					
		11					
		12					
		13					
		14					
		15					

34. COMMENTS

35. TOTAL FEE CHARGED	
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	01/01/2022

39. THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE.

X Dr. John Smith — 01/01/2022

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.