CCS DENTAL AND ORTHODONTIC CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number

4. Address (number, street) City State ZIP code

5. Contact person	6. Contact telephone number	7. Contact fax number
	( )	( )

8. Contact email address

Client Information

9. Client name—last first middle

10. Gender	11. Date of birth (mm/dd/yy)	12. CCS case number	13. Home phone number
☐ Male ☐ Female			( )

14. Cell phone number	15. Work phone number	16. Email address
( )	( )	

17. Residence address (number, street) *(DO NOT USE P.O. BOX)* City State ZIP code

18. Mailing address (if different) (number, street, P.O. box number) City State ZIP code

19. County of residence	20. Language spoken	21. Name of parent/legal guardian

22. Mother's first and last name	23. Primary care physician (if known)	24. Primary care physician telephone number
		( )

Insurance Information

25. a. Enrolled in Medi-Cal?	25. b. If no, enter Client Index Number (CIN)
☐ Yes ☐ No If yes, send TAR directly to Denti-Cal; no CCS SAR should be submitted	

26. Enrolled in commercial dental insurance plan?	If yes, name of plan
☐ Yes ☐ No	

Requested Services

27. Service Authorization Request for *(check all that apply)*
☐ a. CCS established client Diagnosis/ICD-10:_____ ☐ b. CCS orthodontics ☐ c. Service Code Group (SCG)

28.	29.	30.	31.	32.
Procedure Code/SCG	**Tooth Number/ Letter/Arch**	**Description of Service (Including X-rays, prophylaxis, etc.)**	**Quantity**	**Fee**
			33. Total fee:	

34. Is this a CCS supplemental services request	35. Other documentation attached
☐ Yes ☐ No	☐ Yes ☐ No

36. Comments

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not being processed.

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 page two of this form.

37. Signature of dental provider or authorized designee	38. Date

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter either your Denti-Cal billing number (no group numbers) or NPI.
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.
8. Contact person's email address Enter the email address of the contact person.

Client Information

9. Client name: Enter the client's name—last, first, and middle.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS case number: Enter the client's CCS number. If not known, leave blank.
13. Home phone number: Enter the home phone number where the client or client's legal guardian can be reached.
14. Cell phone number: Enter the cellular phone number where the client or client's legal guardian can be reached.
15. Work phone number: Enter the work phone number where the client or client's legal guardian can be reached.
16. Email address: Enter the email address for the client or client's legal guardian.
17. Residence address: Enter the address of the client. Do not use a P.O. Box number.
18. Mailing address: Enter the mailing address if it is different than number 17.
19. County of residence: Enter residential county of the client.
20. Language spoken: Enter the client's language spoken.
21. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
22. Mother's first and last name: Enter the client's mother's name.
23. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
24. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

25. a. Is child enrolled in Medi-Cal? Mark the appropriate box. If answer is yes, do not send SAR to CCS, send TAR directly to Denti-Cal.
    b. If the answer is no, enter the Client Index Number (CIN).
26. Is child enrolled in a commercial dental insurance plan? Mark the appropriate box. If the answer is yes, enter the name of the commercial dental insurance plan.

Requested Services

27. a. CCS established client: Check if requesting approval for an established CCS client. Write diagnosis or ICD-10 code.
    b. CCS Orthodontics: Check if requesting approval for orthodontic services. (Check a. and b. if both apply.)
    c. Service Code Group (SCG): Check if covered by CCS SCG and enter SCG number in column 25. (Check a., b., & c. if all apply.) SCGs can be found in the Denti-Cal Provider Handbook at http://www.denti-cal.ca.gov/provsrvcs/manuals/handbook2/handbook.pdf. Go to Section 9 Special Programs and scroll to SCGs.
28. Procedure Codes/Service Code Groups: Use the appropriate Denti-Cal American Dental Association's (ADA) Current Dental Terminology (CDT) codes for each service, and/or use CCS Service Code Group(s) (SCG). The CDT codes are found in Section 5 of the Denti-Cal Provider Handbook: http://www.denti-cal.ca.gov/provsrvcs/manuals/handbook2/handbook.pdf and the SCG are found in Section 9 of the Handbook, at http://www.denti-cal.ca.gov/provsrvcs/manuals/handbook2/handbook.pdf. Do not duplicate individual procedure codes included in a SCG. Note: Denti-Cal does not use the latest CDT codes.
29. Tooth number or letter; arch; quadrant: Enter the universal tooth code numbers 1 thru 32 or letters A thru T for tooth reference. Use applicable arch codes U (upper), L (lower). Use quadrant codes UR (upper right), UL (upper left), LR (lower right), and LL (lower left).
30. Description of service: Furnish a brief description for each service. Standard abbreviations are acceptable.
31. Quantity: For the procedures having multiple occurrences, indicate the number of occurrences of the procedure, e.g., multiple radiographs (procedure D0230); number of additional units for general anesthesia (procedure D9221).
32. Fee: Enter your usual and customary fee for the procedure rather than the Denti-Cal Schedule of Maximum Allowances fee.
33. Enter total fee to be charged.
34. Check yes or no box if this is a CCS Supplemental Services Request.
35. Check yes or no box if there is other documentation attached.
36. Comments. Enter any additional comments.

Signature

37. Signature of dental provider: Form must be signed by the dentist, orthodontist, or authorized representative.
38. Date: Enter the date the request is signed.