

**SNC: Carries Risk Assessment (CRA) Moderate Risk**

**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, MI) <b>CURRY, ARTHUR, O</b>		3. SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. PATIENT BIRTHDATE MO <b>12</b> DAY <b>21</b> YR <b>14</b>		5. MEDI-CAL BENEFITS ID CARD NUMBER <b>999999999A</b>	
6. PATIENT ADDRESS				7. PATIENT DENTAL RECORD NUMBER			
CITY, STATE				ZIP CODE		8. REFERRING PROVIDER NPI	
9. RADIOGRAPHS ATTACHED? CHECK IF YES <input type="checkbox"/> HOW MANY?		11. ACCIDENT/INJURY? CHECK IF YES <input type="checkbox"/> EMPLOYMENT RELATED?		13. OTHER DENTAL COVERAGE? CHECK IF YES <input type="checkbox"/> 14. MEDICARE DENTAL COVERAGE? CHECK IF YES <input type="checkbox"/>		15. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES <input type="checkbox"/> 17. CCS CALIFORNIA CHILDREN SERVICES? CHECK IF YES <input type="checkbox"/>	
10. OTHER ATTACHMENTS? YES <input type="checkbox"/>		12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK) YES <input type="checkbox"/>		16. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK) YES <input type="checkbox"/>		18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? YES <input type="checkbox"/>	
19. BILLING PROVIDER NAME (LAST, FIRST, MI) <b>AMNESTY BAY DENTAL CLINIC</b>				20. BILLING PROVIDER NPI <b>1234567890</b>			
21. MAILING ADDRESS <b>1962 LIGHTHOUSE WAY</b>				TELEPHONE NUMBER <b>( 999 ) 999-9999</b>			
CITY, STATE <b>TULARE, CA</b>				ZIP CODE <b>99999-9999</b>			
22. PLACE OF SERVICE OFFICE <input type="checkbox"/> HOME <input type="checkbox"/> CLINIC <input type="checkbox"/> SNE <input type="checkbox"/> ICF <input type="checkbox"/> HOSPITAL IN-PATIENT <input type="checkbox"/> HOSPITAL OUT-PATIENT <input type="checkbox"/> OTHER (PLEASE SPECIFY) <input type="checkbox"/>				BIC Issue Date: _____ EVC #: _____			
<b>EXAMINATION AND TREATMENT</b>							
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	01/01/17		D0602	15.00	1234567890
		2	01/01/17		D1310	46.00	1234567890
		3	01/01/17		D9993	65.00	1234567890
		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	01/01/2017

**X DENTIST SIGNATURE**

01/01/2017

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.

For Domain 2, Providers are only eligible for incentive payments if beneficiary is **age 6 and under**.

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

Manual of Criteria (MOC) treatment procedures are reimbursed through the Prospective Payment System (PPS) and the Medi-Cal FI.





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BIC Issue Date: \_\_\_\_\_

EVC #: \_\_\_\_\_

## EXAMINATION AND TREATMENT

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		3	05/01/17		D9993	65.00	1234567890
		4	05/01/17		D1120	30.00	1234567890
		5	05/01/17		D1206	18.00	1234567890
		6					
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	37. OTHER COVERAGE AMOUNT	
	38. DATE BILLED	05/01/2017

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

**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.

### IMPORTANT NOTE:

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For SNCs, **moderate risk beneficiaries are eligible for one (1) reimbursement** by the Denti-Cal FI. Only Domain 2 incentives above the MOC are reimbursed. This example assumes **that treatment procedures were claimed under PPS** on 1/1/17, and a **CRA procedure bundle was claimed with Denti-Cal** on 1/1/17.

CRA procedure bundles will **need to be performed routinely**, based on risk level, in order to maintain eligibility for increased frequency procedures.