

## FFS &amp; DMC: Carries Risk Assessment (CRA) High 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) <b>QUILL, PETER, J</b>		3. SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. PATIENT BIRTHDATE MO <b>8</b> DAY <b>1</b> YR <b>14</b>		5. MEDI-CAL BENEFITS ID CARD NUMBER <b>999999999A</b>	
6. PATIENT ADDRESS <b>1111 ADDRESS WAY STREET</b>						7. PATIENT DENTAL RECORD NUMBER	
CITY, STATE <b>TULARE, CA</b>						ZIP CODE <b>99999 - 9999</b>	
9. RADIOGRAPHS ATTACHED? CHECK IF YES <input type="checkbox"/>		11. ACCIDENT/INJURY? CHECK IF YES <input type="checkbox"/>		13. OTHER DENTAL COVERAGE? CHECK IF YES <input type="checkbox"/>		16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES <input type="checkbox"/>	
HOW MANY? _____		EMPLOYMENT RELATED? <input type="checkbox"/>		14. MEDICARE DENTAL COVERAGE? <input type="checkbox"/>		17. CCS CALIFORNIA CHILDREN SERVICES? <input type="checkbox"/>	
10. OTHER ATTACHMENTS? <input type="checkbox"/>		12. ELIGIBILITY PENDING? (SEE PROVIDER MANUAL) <input type="checkbox"/>		15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL) <input type="checkbox"/>		18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? <input type="checkbox"/>	
19. BILLING PROVIDER NAME (LAST, FIRST, MI) <b>XANDAR DENTAL CLINIC</b>				20. BILLING PROVIDER NUMBER <b>1234567890</b>			
21. MAILING ADDRESS <b>7175 ORION WAY</b>				TELEPHONE NUMBER ( <b>999</b> ) <b>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"/> SNF <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 #/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 CARIES RISK ASSESS/ HIGH	01/01/17	1	D0603	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 FLUORIDE VARNISH	01/01/17	1	D1206	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.

**Instructions and Clarification**

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

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## TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST, FIRST, MI) <b>QUILL, PETER, J</b>		3. SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. PATIENT BIRTHDATE MO <b>8</b> DAY <b>1</b> YR <b>14</b>		5. MEDI-CAL BENEFITS ID CARD NUMBER <b>999999999A</b>	
6. PATIENT ADDRESS <b>1111 ADDRESS WAY STREET</b>						7. PATIENT DENTAL RECORD NUMBER	
CITY, STATE <b>TULARE, CA</b>						ZIP CODE <b>99999 - 9999</b>	
9. RADIOGRAPHS ATTACHED? CHECK IF YES <input type="checkbox"/>		11. ACCIDENT/INJURY? CHECK IF YES <input type="checkbox"/>		13. OTHER DENTAL COVERAGE? CHECK IF YES <input type="checkbox"/>		16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES <input type="checkbox"/>	
HOW MANY? _____		EMPLOYMENT RELATED? <input type="checkbox"/>		14. MEDICARE DENTAL COVERAGE? <input type="checkbox"/>		17. CCS CALIFORNIA CHILDREN SERVICES? <input type="checkbox"/>	
10. OTHER ATTACHMENTS? <input type="checkbox"/>		12. ELIGIBILITY PENDING? (SEE PROVIDER MANUAL) <input type="checkbox"/>		15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL) <input type="checkbox"/>		18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? <input type="checkbox"/>	
19. BILLING PROVIDER NAME (LAST, FIRST, MI) <b>XANDAR DENTAL CLINIC</b>				20. BILLING PROVIDER NUMBER <b>1234567890</b>			
21. MAILING ADDRESS <b>7175 ORION WAY</b>				TELEPHONE NUMBER ( <b>999</b> ) <b>999-9999</b>			
CITY, STATE <b>TULARE, CA</b>				ZIP CODE <b>99999-9999</b>			
22. PLACE OF SERVICE							
OFFICE	HOME	CLINIC	SNF	ICF	HOSPITAL IN-PATIENT	HOSPITAL OUT-PATIENT	OTHER (PLEASE SPECIFY)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BIC Issue Date: _____							
EVC #: _____							
<b>EXAMINATION AND TREATMENT</b>							
26. TOOTH #/LTR. 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 CARIES RISK ASSESS/ HIGH	04/01/17	1	D0603	15.00	1234567890
		2 NUTRITIONAL COUNSELING	04/01/17	1	D1310	46.00	1234567890
		3 MOTIVATIONAL INTERVIEW	04/01/17	1	D9993	65.00	1234567890
		4 PROPHYLAXIS - CHILD	04/01/17	1	D1120	30.00	1234567890
		5 ② APPLICATION FLUORIDE VARNISH	04/01/17	1	D1206	18.00	1234567890
		6 INTERIM CARIES ARRESTING MEDI	04/01/17	1	D1354	35.00	1234567890
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					
34. COMMENTS						35. TOTAL FEE CHARGED	174.00
						36. PATIENT SHARE-OF-COST AMOUNT	
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**X DENTIST SIGNATURE**

04/01/2017

SIGNATURE

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## 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

- Beneficiaries who are categorized as **high risk** are eligible for increased frequencies, **once every 3 months**, for procedures (D1120, D1206 or D1208, and D0120) after Manual of Criteria (MOC) has been billed and processed.
- Additionally, beneficiaries who are categorized as **high risk** are also eligible for procedure D1354, **once every 6 months**.



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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) <input type="checkbox"/>							
BIC Issue Date: _____							
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		1 CARIES RISK ASSESS/ HIGH	07/01/17	1	D0603	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 - CHLD	07/01/17	1	D1120	30.00	1234567890
		5 APPLICATION OF FLUORIDE	07/01/17	1	D1208	18.00	1234567890
		6 PERIODIC ORAL EVALUATION	07/01/17	1	D0120	15.00	1234567890
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					
34. COMMENTS						35. TOTAL FEE CHARGED	189.00
						36. PATIENT SHARE-OF-COST AMOUNT	
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 SIGNATURE

07/01/2017

DATE

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**Instructions and Clarification**

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