

## FFS &amp; DMC: Carries Risk Assessment (CRA) Moderate 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>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 <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"/> HOW MANY? _____	11. ACCIDENT/INJURY? CHECK IF YES <input type="checkbox"/> EMPLOYMENT RELATED? _____	13. OTHER DENTAL COVERAGE? CHECK IF YES <input type="checkbox"/> MEDICARE DENTAL COVERAGE? _____	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES <input type="checkbox"/> CCS CALIFORNIA CHILDREN SERVICES? MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? CHECK IF YES <input type="checkbox"/>	
10. OTHER ATTACHMENTS? YES <input type="checkbox"/>	12. ELIGIBILITY PENDING? (SEE PROVIDER MANUAL) YES <input type="checkbox"/>	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL) 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 NUMBER <b>1234567890</b>		
21. MAILING ADDRESS <b>1962 LIGHTHOUSE WAY</b>		( 999 ) 999-9999		
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)		BIC Issue Date: _____ EVC #: _____		
1 2 3 4 5 6 7 8				

**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 CARIES RISK ASSESS - MODERATE	01/01/17	1	D0602	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	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	
	38. DATE BILLED	01/01/2017

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.

**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**

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

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

1. PATIENT NAME (LAST, FIRST, MI.) <b>CURRY, ARTHUR, O</b>		3. SEX M F		4. PATIENT BIRTHDATE MO DAY YR <b>12 21 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>		8. REFERRING PROVIDER NUMBER
9. CHECK IF YES <b>RADIOGRAPHS ATTACHED?</b>		11. CHECK IF YES <b>ACCIDENT/INJURY?</b>		13. CHECK IF YES <b>OTHER DENTAL COVERAGE?</b>		16. CHDP CHECK IF YES <b>CHILD HEALTH AND DISABILITY PREVENTION?</b>	
HOW MANY? _____		EMPLOYMENT RELATED?		14. YES <b>MEDICARE DENTAL COVERAGE?</b>		17. YES <b>CCS CALIFORNIA CHILDREN SERVICES?</b>	
10. YES <b>OTHER ATTACHMENTS?</b>		12. YES <b>ELIGIBILITY PENDING?</b> (SEE PROVIDER MANUAL)		15. YES <b>RETROACTIVE ELIGIBILITY?</b> (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL)		18. YES <b>MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?</b>	
19. BILLING PROVIDER NAME (LAST, FIRST, MI.) <b>AMNESTY BAY DENTAL CLINIC</b>				20. BILLING PROVIDER NUMBER <b>1234567890</b>			
21. MAILING ADDRESS <b>1962 LIGHTHOUSE WAY</b>				TELEPHONE NUMBER ( 999 ) <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) <b>1 2 3 4 5 6 7 8</b>				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 – MODERATE	05/01/17	1	D0602	15.00	1234567890
		2 NUTRITIONAL COUNSELING	05/01/17	1	D1310	46.00	1234567890
		① MOTIVATIONAL INTERVIEW	05/01/17	1	D9993	65.00	1234567890
		4 PROPHYLAXIS - CHILD	05/01/17	1	D1120	30.00	1234567890
		5 APPLICATION FLUORIDE VARNISH	05/01/17	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	
						38. DATE BILLED	05/01/2017
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.							

**X DENTIST SIGNATURE**  
SIGNATURE

05/01/2017

**SIGNATURE**

DATE \_\_\_\_\_

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### Instructions and Clarification

1. Beneficiaries who are categorized as **moderate risk** are eligible for increased frequencies, **once every 4 months**, for procedures (D1120, D1206 or D1208, and D0120) after Manual of Criteria (MOC) has been billed and processed.



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**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 <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? <input type="checkbox"/>		11. ACCIDENT/INJURY? <input type="checkbox"/>		13. OTHER DENTAL COVERAGE? <input type="checkbox"/>		16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? <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>AMNESTY BAY DENTAL CLINIC</b>				20. BILLING PROVIDER NUMBER <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"/> 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 #/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 – MODERATE	09/01/17	1	D0602	15.00	1234567890
		2 NUTRITIONAL COUNSELING	09/01/17	1	D1310	46.00	1234567890
		3 MOTIVATIONAL INTERVIEW	09/01/17	1	D9993	65.00	1234567890
		4 PROPHYLAXIS - CHILD	09/01/17	1	D1120	30.00	1234567890
		5 APPLICATION FLUORIDE	09/01/17	1	D1208	18.00	1234567890
		6 PERIODIC ORAL EVALUATION	09/01/17	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	
						37. OTHER COVERAGE AMOUNT	
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**X DENTIST SIGNATURE**  
SIGNATURE

09/01/2017

DATE

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**Instructions and Clarification**

1. Eligibility for increased frequency **will only take effect after** a CRA procedure bundle is submitted, and in the beneficiary history.
2. CRA procedure bundles will **need to be performed routinely**, based on risk level frequencies, in order to maintain eligibility for increased frequency procedures.