

FFS & DMC: Carries Risk Assessment (CRA) Low 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) STRANGE, STEPHEN, V		3. SEX M F		4. PATIENT BIRTHDATE MO DAY YR 11 4 14		5. MEDI-CAL BENEFITS ID CARD NUMBER 999999999A	
6. PATIENT ADDRESS 1111 ADDRESS WAY STREET						7. PATIENT DENTAL RECORD NUMBER	
CITY, STATE TULARE, CA				ZIP CODE 99999 - 9999		8. REFERRING PROVIDER NUMBER	
9. RADIOGRAPHS ATTACHED? CHECK IF YES		11. ACCIDENT/INJURY? CHECK IF YES		13. OTHER DENTAL COVERAGE? CHECK IF YES		16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES	
HOW MANY?		EMPLOYMENT RELATED?		14. MEDICARE DENTAL COVERAGE?		17. CCS CALIFORNIA CHILDREN SERVICES?	
10. OTHER ATTACHMENTS? YES		12. ELIGIBILITY PENDING? (SEE PROVIDER MANUAL) YES		15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL) YES		18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? YES	
19. BILLING PROVIDER NAME (LAST, FIRST, MI) SANCTUM SANTORUM CLINIC				20. BILLING PROVIDER NUMBER 1234567890			
21. MAILING ADDRESS 177A BLEEKER STREET				TELEPHONE NUMBER (999) 999-9999			
CITY, STATE TULARE, CA				ZIP CODE 99999-9999			
22. PLACE OF SERVICE							
OFFICE	HOME	CLINIC	SNF	ICF	HOSPITAL IN-PATIENT	HOSPITAL OUT-PATIENT	OTHER (PLEASE SPECIFY)
1	2	3	4	5	6	7	8

BIC Issue Date: _____

EVC #: _____

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 – LOW	01/01/17	1	D0601	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 FLUROIDE	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	
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 _____ 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 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**.

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TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST, FIRST, MI) STRANGE, STEPHEN, V		3. SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. PATIENT BIRTHDATE MO: 11 DAY: 4 YR: 14		5. MEDI-CAL BENEFITS ID CARD NUMBER 99999999A	
6. PATIENT ADDRESS 1111 ADDRESS WAY STREET					7. PATIENT DENTAL RECORD NUMBER		
CITY, STATE TULARE, CA				ZIP CODE 99999 - 9999		8. REFERRING PROVIDER NUMBER	
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"/>		16. 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 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) SANCTUM CANTORUM CLINIC				20. BILLING PROVIDER NUMBER 1234567890			
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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 #: _____

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 - LOW	07/01/17	1	D0601	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 - CHILD	07/01/17	1	D1120	30.00	1234567890
		5 APPLICATION FLUORIDE VARNISH	07/01/17	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	07/01/2017

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X DENTIST SIGNATURE _____ DATE 07/01/2017
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:
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- Instructions and Clarification**
- Beneficiaries who are categorized as **low risk** are **not eligible** for increased frequencies for procedures (D1120, D1206 or D1208, and D0120).
 - Manual of Criteria (MOC) procedure frequencies apply.