DO NOT WRITE IN THIS AREA

SNC: Carries Risk Assessment (CRA) Low 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, M.I.)	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YR	5. MEDI-CAL BENEFITS ID CARD NUMBER
STRANGE, STEPHEN, V		11 / 4 / 16	99999999A

6. PATIENT ADDRESS

7. PATIENT DENTAL RECORD NUMBER

CITY, STATE — ZIP CODE

8. REFERRING PROVIDER NPI

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?	YES	14. MEDICARE DENTAL COVERAGE?	YES	17. CCS CALIFORNIA CHILDREN SERVICES?	YES
10. OTHER ATTACHMENTS?	YES	12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK)	YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK)	YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	YES

19. BILLING PROVIDER NAME (LAST, FIRST, M.I.)	20. BILLING PROVIDER NPI
SANCTUM SANTORUM CLINIC	1234567890
21. MAILING ADDRESS	TELEPHONE NUMBER
177A BLEEKER STREET	(999) 999-9999
CITY, STATE	ZIP CODE
TULARE, CA	99999-9999

BIC Issue Date: _____

EVC #: _____

22. PLACE OF SERVICE: OFFICE (1) HOME (2) CLINIC (3) SNF (4) ICF (5) HOSPITAL IN-PATIENT (6) HOSPITAL OUT-PATIENT (7) OTHER (PLEASE SPECIFY) (8)

EXAMINATION AND TREATMENT

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		D0601	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	
38. DATE BILLED	01/01/2017

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

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 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.

Carries Risk Assessment (CRA) procedures must be performed on the **same service date**, and **claimed on the same Treatment Authorization Request claim**.

For SNCs, Manual of Criteria (MOC) frequencies for treatment procedures are still reimbursed through the Prospective Payment System (PPS), and the Medi-Cal FI.

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EXAMINATION AND TREATMENT

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	07/01/17		D0601	15.00	1234567890
		2	07/01/17		D1310	46.00	1234567890
		3	07/01/17		D9993	65.00	1234567890
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
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		13					
		14					
		15					

34. COMMENTS

35. TOTAL FEE CHARGED	
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	07/01/2017

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

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07/01/2017 — DATE

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Beneficiaries categorized as **low risk** are **not eligible** for increased frequencies, MOC frequencies apply.

SNCs will be reimbursed through the PPS system and Medi-Cal FI.

SNCs can bill the CRA procedure bundle to Denti-Cal FI as shown.