DO NOT WRITE IN THIS AREA

SNC: Carries Risk Assessment (CRA) High 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
QUILL, PETER, J		8 / 1 / 14	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
XANDAR DENTAL CLINIC	1234567890
21. MAILING ADDRESS	TELEPHONE NUMBER
7175 ORION WAY	(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		D0603	15.00	1234567890
		2	01/01/17		D1310	46.00	1234567890
		3	01/01/17		D9993	65.00	1234567890
		4					
		5					
		6					
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		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.

For Domain 2, Providers are only eligible for incentive payments if beneficiary is **age 6 and under**.
CRA bundle procedures must be performed on the **same service date**, and claimed on the **same Treatment Authorization Request form**.
Manual of Criteria (MOC) frequencies are reimbursed through the Prospective Payment System (PPS) and the Medi-Cal FI

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QUILL, PETER, J		8 / 1 / 14	99999999A

6. PATIENT ADDRESS

7. PATIENT DENTAL RECORD NUMBER

CITY, STATE

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8. REFERRING PROVIDER NPI

9. RADIOGRAPHS ATTACHED? HOW MANY?	CHECK IF	YES	11. ACCIDENT/INJURY? EMPLOYMENT RELATED?	CHECK IF / YES	13. OTHER DENTAL COVERAGE? / 14. MEDICARE DENTAL COVERAGE?	CHECK IF / YES	YES / YES	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? / 17. CCS CALIFORNIA CHILDREN SERVICES?	CHECK IF / YES / 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

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XANDAR DENTAL CLINIC	1234567890
21. MAILING ADDRESS	TELEPHONE NUMBER
7175 ORION WAY	(999) 999-9999
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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	04/01/17		D0603	15.00	1234567890
		2	04/01/17		D1310	46.00	1234567890
		3	04/01/17		D9993	65.00	1234567890
		4	04/01/17		D1120	30.00	1234567890
		5	04/01/17		D1206	18.00	1234567890
		6					
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		8					
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		10					
		11					
		12					
		13					
		14					
		15					

1

34. COMMENTS

35. TOTAL FEE CHARGED	
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	04/01/2017

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

X DENTIST SIGNATURE — SIGNATURE

04/01/2017 — DATE

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For SNCs, **high risk beneficiaries are eligible for two (2) reimbursements** by the Denti-Cal FI. Only Domain 2 incentives, above the MOC are reimbursed. This example assumes that treatment procedures were claimed under PPS with a 1/1/17 date of service

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

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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
XANDAR DENTAL CLINIC	1234567890
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EXAMINATION AND TREATMENT

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		1	10/01/17		D0603	15.00	1234567890
		2	10/01/17		D1310	46.00	1234567890
		3	10/01/17		D9993	65.00	1234567890
		4	10/01/17		D1208	18.00	1234567890
		5	10/01/17		D1120	30.00	1234567890
		6	2 10/01/17		D0120	15.00	1234567890
		7	10/01/17		D1354	35.00	1234567890
		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	10/01/2017

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

X DENTIST SIGNATURE — SIGNATURE

10/01/2017 — DATE

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Only Domain 2 incentives, above the MOC are reimbursed. This example assumes that **treatment procedures were claimed under PPS** on 1/1/17 & 7/1/17, and a **CRA procedure bundle was claimed with Denti-Cal** on 7/1/17.
Beneficiaries who are categorized as high risk are eligible for interim caries arresting medicament (D1354), **once every six (6) months**.