DO NOT WRITE IN THIS AREA

DHCS | Medi-Cal Dental
PO BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
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
LASTNAME, FIRST NAME M		02 / 02 / 17	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
Dental Clinic	9999999999
21. MAILING ADDRESS	TELEPHONE NUMBER
123 Any Street	(999) 999-9999
CITY, STATE	ZIP CODE
Anytown, CA	99999-9999

BIC Issue Date: _____

EVC #: _____

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

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	01/01/2022		D1120	$22.50	9999999999
		2	01/01/2022		D1206	$13.50	9999999999
		3					
		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	01/01/2022

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

X Dr. John Smith
SIGNATURE

01/01/2022
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.