DO NOT WRITE IN THIS AREA

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, M.I.)
3. SEX M F
4. PATIENT BIRTHDATE MO DAY YR
5. MEDI-CAL BENEFITS ID CARD NUMBER
6. PATIENT ADDRESS
7. PATIENT DENTAL RECORD NUMBER
CITY, STATE
ZIP CODE
8. REFERRING PROVIDER NPI

9. CHECK IF YES — **RADIOGRAPHS ATTACHED?**
HOW MANY? ____________
10. YES — **OTHER ATTACHMENTS?**
11. CHECK IF YES — **ACCIDENT/INJURY?**
YES — **EMPLOYMENT RELATED?**
12. YES — **ELIGIBILITY PENDING?** (SEE PROVIDER HANDBOOK)
13. CHECK IF YES — **OTHER DENTAL COVERAGE?**
14. YES — **MEDICARE DENTAL COVERAGE?**
15. YES — **RETROACTIVE ELIGIBILITY?** (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK)
16. CHECK IF YES — **CHDP CHILD HEALTH AND DISABILITY PREVENTION?**
17. YES — **CCS CALIFORNIA CHILDREN SERVICES?**
18. YES — **MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?**

19. BILLING PROVIDER NAME (LAST, FIRST, M.I.)
20. BILLING PROVIDER NPI
21. MAILING ADDRESS
TELEPHONE NUMBER ( )
CITY, STATE
ZIP CODE
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 #/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					
		2					
		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**	

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 ______________________________ ______________
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 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.