



**TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM**

1. PATIENT NAME (LAST, FIRST, MI.)		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. RADIOGRAPHS ATTACHED? CHECK IF YES HOW MANY?		11. ACCIDENT/INJURY? CHECK IF YES EMPLOYMENT RELATED?		13. OTHER DENTAL COVERAGE? CHECK IF YES 14. MEDICARE DENTAL COVERAGE?		16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES			
10. OTHER ATTACHMENTS? YES		12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK) YES		15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK) YES		17. CCS CALIFORNIA CHILDREN SERVICES? YES			
18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? YES		19. BILLING PROVIDER NAME (LAST, FIRST, MI.)		20. BILLING PROVIDER NPI		BIC Issue Date: _____  EVC #: _____			
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					

**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					
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		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 THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE.

**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.

