CCS DENTAL AND ORTHODONTIC CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Denti-Cal provider number

4. Address (number, street) City State ZIP code

5. Contact person	6. Contact telephone number ( )	7. Contact fax number ( )

Client Information

8. Client name—last first middle

9. Gender ☐ Male ☐ Female	10. Date of birth (mm/dd/yy)	11. CCS case number	12. Contact phone number ( )

13. Residence address (number, street) *(DO NOT USE P.O. BOX)* City State ZIP code

14. Mailing address (if different) (number, street, P.O. box number) City State ZIP code

15. County of residence	16. Language spoken	17. Name of parent/legal guardian

18. Mother's first name	19. Primary care physician (if known)	20. Primary care physician telephone number ( )

Insurance Information

21. a. Enrolled in Medi-Cal? ☐ Yes ☐ No If yes, send TAR directly to Denti-Cal	21. b. If no, Client Index Number (CIN)

22. Enrolled in Healthy Families? ☐ Yes ☐ No	If yes, name of plan

23. Enrolled in commercial dental insurance plan? ☐ Yes ☐ No	If yes, name of plan

Requested Services

24. Service Authorization Request for *(check one)*
☐ a. CCS established client ☐ b. CCS orthodontics

25. Tooth Number or Letter Arch	26. Surfaces	27. Description of Service (Including X-rays, prophylaxis, etc.)	28. Quantity	29. Procedure Number	30. Fee

31. Is this a CCS supplemental services request ☐ Yes ☐ No	32. Other documentation attached ☐ Yes

33. Comments

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 page two of this form.

34. Signature of dental provider or authorized designee	35. Date

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Denti-Cal provider number: Enter Denti-Cal billing number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Gender: Check the appropriate box.
10. Date of birth: Enter the client's date of birth.
11. CCS case number: Enter the client's CCS number. If not known, leave blank.
12. Contact phone number: Enter the phone number where the client or client's legal guardian can be reached.
13. Residence address: Enter the address of the client. Do not use a P.O. Box number.
14. Mailing address: Enter the mailing address if it is different than number 13.
15. County of residence: Enter residential county of the client.
16. Language spoken: Enter the client's language spoken.
17. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
18. Mother's first name: Enter the client's mother's first name.
19. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
20. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

21. a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, do not send this SAR to CCS, send a TAR directly to Denti-Cal.
    b. If the answer is no, enter the Client Index Number (CIN).
22. Enrolled in Healthy Families? Mark the appropriate box. If the answer is yes, enter the name of the plan.
23. Enrolled in a commercial dental insurance plan? Mark the appropriate box. If the answer is yes, enter the name of the commercial dental insurance plan.

Requested Services

24. a. CCS established client: Check if requesting approval for an established CCS client.
    b. CCS Orthodontics: Check if requesting approval for orthodontic services.
25. Tooth number or letter; arch; quadrant: Enter the universal tooth code numbers 1 thru 32 or letters A thru T for tooth reference. Use arch codes U (upper), L (lower). Use quadrant codes UR (upper right), UL (upper left), LR (lower right), and LL (lower left).
26. Tooth surfaces: Use M (mesial), D (distal), O (occlusal), I (incisal), L (lingual or palatal), B (buccal), and F (facial).
27. Description of service: Furnish a brief description for each service. Standard abbreviations are acceptable.
28. Quantity: For the procedures having multiple occurrences, indicate the number of occurrences of the procedure, e.g., multiple radiographs (procedure 111), units for prosthetic procedures (procedure 716), or number of pins (procedure 648).
29. Procedure numbers: Use a Denti-Cal three-digit, state-approved four-digit, or state-approved five-digit code for each service. NOTE: Do not mix different types of codes when completing a claim or TAR form.
30. Fee: Enter your usual and customary fee for the procedure rather than the Denti-Cal Schedule of Maximum Allowances fee.
31. Check yes or no box if this is a CCS Supplemental Services Request.
32. Check the box if there is other documentation attached.
33. Comments. Enter any additional comments.

Signature

34. Signature of dental provider: Form must be signed by the dentist, orthodontist, or authorized representative.
35. Date: Enter the date the request is signed.