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Section 6 - Forms

Medi-Cal Dental Forms

Only Medi-Cal Dental specific, State-approved forms are accepted by Medi-Cal Dental. Any other forms will be returned without processing. Proper use and completion of these forms will expedite authorization or payment for Medi-Cal dental covered services. No duplicates or photocopies will be accepted or processed. Signatures in blue or black ink are required: rubber signature stamps will not be accepted.

Treatment Authorization Request (TAR)/ Claim Forms

- DC-202 – Preimprinted, No Carbon Required (NCR)
- DC-209 – NCR for continuous pin-fed printers
- DC-217 – Single sheet for laser printers

Claim Inquiry Forms (CIFs)

- DC-003

Envelopes for TAR/Claim Forms/ Correspondence

- DC-006C – for submitting radiographs/attachments for Electronic Data Interchange (EDI) TAR/Claims forms
- DC-007 - correspondence
- DC-206 – for submitting TAR/Claim forms that are not EDI

Envelopes for Submitting Radiographs Associated with EDI Documents

- DC-014E – large envelopes for submitting radiographs/documentation for EDI documents
- DC-014F – small envelopes for submitting radiographs/documentation for EDI documents
- DC-006C – large envelopes for mailing multiple large/small envelopes (DC-014E and DC-014F).

EDI Labels

- DC-018A – 12-up sheet of labels for laser printers (order blank or preimprinted)
- DC-018B – 1-up continuous labels
- DC-018C - 3-up continuous labels

Ordering Forms

When ordering forms, be sure to request an adequate supply of TAR/Claim forms, CIFs, and Justification of Need for Prosthesis forms, plus X-ray and mailing envelopes. The Forms Reorder Request (DC-204) is to be used to order forms from Medi-Cal Dental's forms supplier.

The forms vendor will verify that the National Provider Identifier (NPI) number submitted for preimprinting matches what is on record at Medi-Cal Dental. Once confirmed, the inventory will be preimprinted with the NPI. However, if the information found on the Forms Reorder Request does not match what the forms vendor has received from Medi-Cal Dental, the order will not be filled.

The Forms Reorder Request form (DC-204) should be mailed or faxed to the warehouse vendor:

Medi-Cal Dental Forms Reorder
11155 International Drive, MS C25
Rancho Cordova, CA 95670
Fax: (877) 401-7534

Do not phone the warehouse: they are not staffed to handle telephone requests.

Upon receiving Medi-Cal dental forms and envelopes, verify that any pre-printed information such as address and/or NPI number is correct. If there are errors, then please call the Telephone Service Center toll-free at (800) 423-0507.

Optical Character Recognition (OCR)/Intelligent Character Recognition (ICR)

OCR/ICR technology allows for a more automated process of capturing information from paper documents and enables Medi-Cal Dental to electronically adjudicate paper forms. Medi-Cal Dental's goal is to decrease processing time, improve responsiveness to provider and member (patient) inquiries, and increase adjudication accuracy.

To ensure optimum results and avoid denials, please follow the specifications listed below.

Do:

- Use only Medi-Cal Dental provided forms
- On TAR/Claim forms, leave boxes 11 through 18 blank, unless indicating "yes." OCR reads any mark in boxes 11 through 18 as a "yes" even if the answer is "no."
- Use a laser printer for best results. If handwritten documents must be submitted, use neat block letters, blue or black ink, and stay within field boundaries.
- Use a 10 point, plain font (such as Arial), and use all capital letters.
- Use a 6-digit date format without dashes or slashes, e.g., mmddyy (123116).
- Use only Medi-Cal Dental TAR/Claim forms
- Print within the lines of the appropriate field
- Submit notes and attachments on 8 ½" by 11" paper. Small attachments must be taped to standard paper in order to go through the scanner.
- Submit notes and attachments on one side of the paper only. Double-sided attachments require copying and additional preparation for the scanners which will cause delays in adjudication.
- Enter quantity information in the quantity field. OCR does not read

Do Not:

- Use correction fluid or tape.
- Use a dot matrix/impact printer.
- Use italics or script fonts.
- Mix fonts on the same form.
- Use fonts smaller than 10 point.
- Use arrows or quote/ditto marks to indicate duplicate dates of service, National Provider Identifier (NPI), etc.
- Use dashes or slashes in date fields.
- Print slashed zeros.
- Use photocopies of any Medi-Cal dental forms.
- Use highlighters to highlight field information (this causes field data to turn black and become unreadable).
- Submit two-sided attachments.
- Enter quantity information in the description of service field.
- Put notes on the top or bottom of forms
- Fold any forms.
- Use labels, stickers, or stamps on any Medi-Cal dental forms.
- Use rubber signature or "signature on file" stamps.
- Place additional forms, attachments, or documentation inside the X-ray envelope. This will cause a delay in adjudication and processing.

the description of service field to pick up the quantity.

- On TAR/Claim forms, complete boxes 19 and 20. Enter the complete Billing Provider Name and NPI to ensure appropriate payment to the correct billing number.
- Remember that the following TAR/Claim forms are no longer available and should not be used: DC-002A, DC-002B, DC-009A, DC-009B, DC-017A, and DC-017B.
- Always apply a handwritten signature in blue or black ink.

Correct Use of Medi-Cal Dental Envelopes

Medi-Cal Dental continues to receive X-ray envelopes that are incorrectly addressed or prepared, have no address, or are empty. Some providers also submit radiographs without using the correct preimprinted or typed X-ray envelopes specifically designed for that purpose. Radiographs and photographs will not be returned.

- When submitting claims for multiple patients in one envelope, ensure that the radiographs/photographs for the respective patient are stapled to the associated claim/TAR. Use only one staple in upper right or left corner of the claim/TAR to attach radiographs or paper copies.
- Do not print two separate documents on one piece of paper (e.g., an EDI Notice of Authorization for one member on one side, and another EDI Notice of Authorization for a different member on the other side).
- Enclose mounted, dated, and well-marked radiographs and photographs in the appropriate X-ray envelope. Include the dentist's name, Medi-Cal dental provider number, and member name and Medi-Cal ID number on the X-Ray mount. Duplicate radiographs, paper radiographs, and photographs should also be marked clearly so they are identifiable for processing. The date on all radiographs, paper copies, and photographs must be in month/date/year format.
- Plastic sleeve mounts should be clean and have the label containing the required information placed on the front side of the mount.
- If the provider has a device such as a scanner that can transfer radiographs onto paper, Medi-Cal Dental will accept the paper copy instead of the regular film. Paper copies of radiographs must be of good quality to be accepted and must be larger than 2 inches by 3.5 inches (about the size of a business card). If the resolution of the paper image is inadequate, Medi-Cal Dental will request the original film, which can delay processing. Be sure to indicate on the paper copy the date the radiograph was taken and which side of the mouth. Paper copies of radiographs will not be returned.
- Paper copies should be printed on 20lb or heavier paper, but do not use glossy or photo paper.
- Do not fold radiographs or photographs.
- Only use X-ray envelopes for radiographs or paper radiographs. All other attachments and documentation should be stapled to the TAR/Claim form to reduce processing delays. Do not overfill X-ray envelopes. The appropriately-sized envelopes should be used for all radiographs submitted to prevent damaged envelopes and/or lost radiographs.
- Up to three unmounted radiographs may be submitted by placing them in unsealed
  coin-size envelopes and inserting the coin-size envelopes into the X-ray

envelopes provided by Medi-Cal Dental. The coin-sized envelope should be labeled with the provider name, NPI, member name, and date.

Medi-Cal Dental offers the following special envelopes printed with red borders to be used by the dental office for enclosing radiographs, photographs, and other documentation associated with EDI claims and TARs:

- **DC-014E** – Large envelope for submitting radiographs and/or other documentation associated with EDI documents
- **DC-014F** – Small envelope for submitting radiographs and/or other documentation associated with EDI documents

Radiographs or paper printouts of digitized images should be placed in these envelopes. Loose radiographs can become separated and lost, which can delay the time it takes Medi-Cal Dental to process documents. One EDI mailing label should be affixed to each envelope: DC-018A (can be ordered partially preimprinted), DC-018B or C.

Medi-Cal Dental also provides the following envelope for mailing several small or large EDI radiograph envelopes:

- **DC-006C** – Large envelope with red border which should only contain:
  - Multiple EDI X-ray envelopes DC-014E and DC-014F containing radiographs or documentation related to EDI claims and TARs.

- **DC-206** – Large envelope for mailing TAR/Claim forms, which should only contain:
  - TAR/Claim forms
  - Claim Inquiry Forms (CIFs)
  - Resubmission Turnaround Documents (RTDs) relating to TAR/Claim forms
  - NOAs submitted for payment or reevaluation
  - EDI NOAs printed onto paper for payment and/or EDI RTDs printed onto paper related to claims (do not attach EDI label)
  - EDI RTDs printed onto paper related to TARs (do not attach EDI label)

Treatment Authorization Request (TAR)/Claim Forms

The TAR/Claim form is used to request authorization of proposed treatment or submit a claim for payment. Accurate completion of this form is required to ensure proper and expeditious handling by Medi-Cal Dental. An incomplete or inaccurate TAR or Claim will delay processing and may result in the generation of a RTD or denial.

Medi-Cal Dental specific forms are the only forms processed under Medi-Cal Dental, whether for authorization of covered services or payment of rendered treatment.

The format of the following forms is identical.

- DC-202 (No Carbon Required (NCR) TAR/Claim forms)
- DC-209 (continuous TAR/Claim forms)
  Page 1 – Submit first sheet to
  Medi-Cal Dental
  Page 2 – Retain second sheet
- DC-217 (single-sheet TAR/Claim forms for use in laser printers)

For scanning purposes, the forms are produced with red ink, and providers are requested to use only blue or black ink on any forms submitted to Medi-Cal Dental.

Please make sure all applicable areas of the forms are filled in completely and accurately. Any claim service line (CSL) submitted with an invalid procedure code, or a blank procedure code field will be denied, whether submitted electronically or as paper documents. Documents received with a missing or incorrect address or NPI can delay the processing of TARs and claims and increase the possibility that payments may be forwarded to the wrong office.

Sample TAR/Claim Form Submitted as a Treatment Authorization Request (TAR)

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
MEMBER, JANE	X	07 / 04 / 55	9999999999

6. PATIENT ADDRESS	7. PATIENT DENTAL RECORD NUMBER
5498 PRIMROSE WAY	

CITY, STATE	ZIP CODE	8. REFERRING PROVIDER NPI
ANYTOWN, CA	90100	

9. RADIOGRAPHS ATTACHED? HOW MANY? _____	CHECK IF YES	11. ACCIDENT/INJURY? EMPLOYMENT RELATED?	CHECK IF YES	13. OTHER DENTAL COVERAGE?	CHECK IF YES	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION?	CHECK IF YES
			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
ADAMS, JAMES	1234567891

21. SERVICE OFFICE ADDRESS	TELEPHONE NUMBER
3157 MAIN ST, STE 320	(888) 555-0188

CITY, STATE	ZIP CODE
ANYTOWN, CA	90100

22. PLACE OF SERVICE

OFFICE	HOME	CLINIC	SNF	ICF	HOSPITAL IN-PATIENT	HOSPITAL OUT-PATIENT	OTHER (PLEASE SPECIFY)
X	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
U		1 PARTIAL DENTURE - RESIN BASE			D5211	250.00	
L		2 PARTIAL DENTURE - RESIN BASE			D5212	250.00	
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

34. COMMENTS

35. TOTAL FEE CHARGED	500.00
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	10242020

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 Jim Adams (SIGNATURE) 10/27/20 (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.

www.denti-cal.ca.gov

DC-217 (R 10/19)

Sample

Sample TAR/Claim Form Submitted as a Claim

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.) MEMBER, JANE	3. SEX M / F: X	4. PATIENT BIRTHDATE MO 07 DAY 04 YR 55	5. MEDI-CAL BENEFITS ID CARD NUMBER 9999999999
6. PATIENT ADDRESS 5498 PRIMROSE WAY			7. PATIENT DENTAL RECORD NUMBER
CITY, STATE ANYTOWN, CA		ZIP CODE 90100	8. REFERRING PROVIDER NPI

9. CHECK IF RADIOGRAPHS ATTACHED? HOW MANY?	YES	11. CHECK IF ACCIDENT/INJURY? EMPLOYMENT RELATED?	YES	13. CHECK IF OTHER DENTAL COVERAGE?	YES	16. CHDP CHECK IF CHILD HEALTH AND DISABILITY PREVENTION?	YES
			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.) ADAMS, JAMES	20. BILLING PROVIDER NPI 1234567891
21. SERVICE OFFICE ADDRESS 3157 MAIN ST, STE 320	TELEPHONE NUMBER (888) 555-0188
CITY, STATE ANYTOWN, CA	ZIP CODE 90100

22. PLACE OF SERVICE

OFFICE	HOME	CLINIC	SNF	ICF	HOSPITAL IN-PATIENT	HOSPITAL OUT-PATIENT	OTHER (PLEASE SPECIFY)
X	2	3	4	5	6	7	8

BIC Issue Date: 01/15/10

EVC #: 123456789A1

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 Exam	111420		D0150	25.00	9912345678
		2 4 BW X-Rays	111420		D0274	18.00	9912345678
		3 Additional PAs	111420	6	D0230	18.00	9912345678
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

34. COMMENTS

35. TOTAL FEE CHARGED	61.00
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	11142020

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 Jim Adams (SIGNATURE) 11/14/20 (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.

Sample

www.denti-cal.ca.gov

DC-217 (R 10/19)

How to Complete the TAR/Claim Form

Accurate and complete preparation of this form is essential for processing. Unless otherwise specified, all fields must be completed.

Medi-Cal Dental's evaluation of TARs and Claims will be more accurate when narrative documentation is included. The following reminders and tips help office staff prepare narrative documentation for some common Medi-Cal dental procedures:

- “Comments” area (Field 34) of the
- TAR/Claim form is used when written narrative documentation is required. If including narrative documentation on a separate piece of paper, check Field 10 on the treatment form to indicate there are other attachments. Note in Field 34 that written comments are attached.
- Written narrative documentation must be legible; printed or typewritten documentation is always preferred. Avoid strikeovers, erasures or using correction fluid when printing or typing narrative documentation on the treatment form
  (Field 34).
- If submitting electronically, abbreviate comments to make optimum use of allotted space.

Fill in each field as follows:

1. **PATIENT NAME**: Enter the member’s last name, first name and middle initial.
2. Field removed.
3. **PATIENT SEX**: Check “M” for male or “F” for female.
4. **PATIENT BIRTHDATE**: Enter the member's birthdate (mmddyy). The birthdate is used to help identify the member. Differences between the birthdate on the Medi-Cal Identification Card and the birthdate given by the member should be brought to the attention of the member for correction by his/her County Social Services office.
5. **MEDI-CAL BENEFITS ID CARD NUMBER**: Enter the member's 14-digit number as it appears on the Medi-Cal identification card. Completion of this field is required.
6. **PATIENT ADDRESS**: Enter the member's current address. If the member resides in a convalescent home or other health care facility, indicate the full name, complete address and phone number, including area code, of the convalescent home or other health care facility.
   Please Note: It is important to accurately document the member’s name, birthdate, Medi-Cal Benefits ID Card number and current address when submitting billing forms to
   Medi-Cal Dental. Medi-Cal Dental may need to contact the member for screening, and if the member’s information is incorrect, it can cause delays in processing the document.

7. **PATIENT DENTAL RECORD NUMBER**: If the provider assigns a Dental Record Number or account number to a member, enter the assigned number here. The number will then appear on all related correspondence from Medi-Cal Dental.
8. **REFERRING PROVIDER NUMBER**: Enter the license number of the dentist who referred the member, if applicable.
9. **RADIOGRAPHS ATTACHED? HOW MANY?** Check if "yes" and indicate the number of films enclosed. All radiographs and any attachments should be clearly identified with the member's name, the BIC or CIN, the date that the radiograph was taken, and the provider's name and provider number.
10. **OTHER ATTACHMENTS**: Check "yes" if additional documents are attached to the TAR/Claim form. Examples of other attachments include related correspondence, periodontal charts, operating room reports or physician's report describing the member's specific medical condition. Do not place attachments inside the X-ray envelope.
11. **ACCIDENT/INJURY? EMPLOYMENT RELATED?** Check "yes" if the member was in an accident or incurred an injury that resulted in the need for dental services. Additionally, if the member's accident or injury was caused by or occurred at work, check "yes." Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
12. **ELIGIBILITY PENDING?** (FOR TAR ONLY) Check "yes" if the member has applied for Medi-Cal eligibility which has not yet been approved and a TAR has been submitted for that member.
    Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
13. **OTHER DENTAL COVERAGE?** Check "yes" if the services performed are either fully or partially covered by a private- or employer-paid dental insurance carrier. The provider must bill the other insurance carrier prior to submitting the TAR/Claim form to Medi-Cal Dental. In the "COMMENTS" section (Field 34), furnish the full name and address of the other insurance carrier, and name and group number of the policy holder. Attach a copy of the other insurance carrier's Explanation of Benefits, fee schedule, or denial letter. For more information on other coverage, see "Section 9: Special Programs" of this Handbook. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
14. **MEDICARE DENTAL COVERAGE?** Check "yes" if the service performed is covered by Medicare. Medicare must be billed prior to submitting any Medicare-covered service to Medi-Cal Dental. Attach a copy of the Explanation of Medicare Benefits form or denial letter. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."

15. **RETROACTIVE ELIGIBILITY?** Check “yes” if the services have been performed and the provider is requesting payment for the reason described in the “COMMENTS” section, Field 34. Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
16. **CHDP (CHILD HEALTH AND DISABILITY PREVENTION)?** Check “yes” if the treatment is related to a previous CHDP screening. The CHDP Children’s Treatment Program (CTP) claims must be submitted with a current PM 160 (health assessment screening form) attached to the Medi-Cal Dental TAR/Claim form. Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
17. **CCS (CALIFORNIA CHILDREN’S SERVICES)?** Check “yes” if any services performed are authorized by CCS. Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
18. **MF-O (MAXILLOFACIAL-ORTHODONTIC) SERVICES?** Check “yes” if the claim is for maxillofacial-orthodontic services. Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
19. **BILLING PROVIDER NAME**: Enter the billing provider's name in either the “doing business as” format, such as HAPPY TOOTH DENTAL CLINIC, or in the last-name, first-name, middle-initial, title format, e.g., SMITH, JOHN J., DDS. This information should be consistent with that used when filing state and federal taxes.
20. **BILLING PROVIDER NUMBER**: Enter the billing Provider Number (NPI). NOTE: The Provider Number and correct service office (where the services were administered) must be present and correct on all forms. Also, the NPI must be registered with Medi-Cal Dental prior to submitting claims.
21. **BILLING PROVIDER ADDRESS AND TELEPHONE NUMBER**: Enter the service office address where treatment is rendered. A service office address should be a street address, including city, state, and zip code. A post office box cannot be used as a service office; however, it is acceptable in rural areas only to use a route number with a post office box number.
    If the service office address is different from the address where payment is received, please notify Medi-Cal Dental so payment can be directed to the appropriate location.
    It is important to include the telephone number of the service office, including area code, so Medi-Cal Dental can contact the provider if questions arise while processing documents.
    Please Note: It is important that the billing provider’s name, Medi-Cal provider number (NPI), address and telephone number are accurate and match the information Medi-Cal Dental has recorded on its system. TAR/Claim forms pre-printed with the provider's name/number/address are available at no charge from the

Medi-Cal dental forms supplier. Please check this information for accuracy on all pre-printed supplies. If forms printed from your office computer are being used, please ensure the computer is programmed with the correct provider information.

22. **PLACE OF SERVICE**: Check the appropriate box indicating where service was performed (claim) or will be performed (TAR), i.e., Office, Home, Clinic/Dental School Clinic, SNF (Skilled Nursing Facility), ICF (Intermediate Care Facility), Hospital In-Patient,
    Hospital Out-Patient or Other (specify place of service). Those providers treating a SNF or ICF member outside the facility in which they reside, must use POS 4 or 5 (only) and must indicate the actual place of service in Box 34.
    BIC ISSUE DATE/EVC# AREA: This area is only used to record the new issue date for Benefits Identification Cards (BICs).
23. Field removed
24. Field removed
25. Field removed
26. **TOOTH NO./LTR, ARCH, QUAD**: Use universal tooth code numbers 1 thru 32 or letters A thru T for tooth reference. Use arch code “U” (upper), “L” (lower). Use quadrant code “UR” (upper right), “UL” (upper left), “LR” (lower right), and “LL” (lower left). For permanent supernumerary teeth continue with numbers 33 — 40. For primary supernumerary teeth, continue with letters U — Z.
27. **TOOTH SURFACES**: Use “M” (mesial), “D” (distal), “O” (occlusal), “I” (incisal), “L” (lingual or palatal), “B” (buccal), and “F” (facial).
28. **DESCRIPTION OF SERVICE**: Furnish a brief description for each service. Standard abbreviations are acceptable.
29. **DATE SERVICE PERFORMED**: For TARs, this field is blank. For payment claims only. Indicate the date the service was performed, using the six numerical digits e.g., mmddyy.
30. **QUANTITY:** For the procedures having multiple occurrences, indicate the number of occurrences of the procedure.
31. **PROCEDURE NUMBERS**: Use only the Current Dental Terminology version 2022 (CDT 22) procedure codes.
32. **FEE**: Enter the usual customary and reasonable (UCR) fee for the procedure rather than the Medi-Cal Dental Schedule of Maximum Allowances fee.
33. **RENDERING PROVIDER NO**.: A rendering provider (NPI) number is required in Field 33 on all claim forms and NOAs for each dated line on the form. Rendering provider numbers are not required on undated lines of a TAR. If a rendering provider number (NPI) is not indicated on the TAR/Claim form for dated services, the TAR/Claim form will be delayed and a RTD will be issued to request the missing information. If there is more than one dentist or dental hygienist at a service office billing under a single dentist's provider number, enter the NPI of the dentist or dental hygienist **who performed the service**.

34. **COMMENTS**: Use for additional clinical remarks necessary to document treatment or for requested information regarding other coverage, etc. Narrative documentation should always state facts as they pertain to the case. Printed or typewritten documentation is preferred. It is helpful to note in this area that narrative documentation is attached when including narrative documentation on a separate piece of paper.
    When preparing a TAR for a member with an authorized representative who is not identified on the Medi-Cal card, please include the representative's name and address in this area on the TAR form. This will assist Medi-Cal Dental in identifying cases where the TAR status notification should be sent to a representative and will help with correct address information.
    This area should also be used to indicate the:
    - Submitter ID of the billing intermediary, if applicable
    - Eligibility confirmation number given by the AEVS when verifying eligibility
    - Name, address, and telephone number of the Skilled Nursing Facility or Intermediate Care Facility
35. **TOTAL FEE CHARGED**: The sum of the fees entered in field 32 for all lines.
36. **PATIENT SHARE OF COST AMOUNT: FOR PAYMENT CLAIMS ONLY**. The dollar amount of the member's share of cost collected by or due from a recipient who has a share of cost obligation. If there is no share of cost, then leave this field blank.
37. **OTHER COVERAGE AMOUNT: FOR PAYMENT CLAIMS ONLY**. The dollar amount of “other coverage” payments the provider has received for the listed procedures. If either Field 13 (OTHER DENTAL COVERAGE) or Field 14 (MEDI-CARE DENTAL COVERAGE) is checked “yes”, the amount received from the private dental insurance carrier or Medicare must be entered. The Explanation of Benefits (EOB) or denial from the private dental insurance carrier or Medicare must be attached to the TAR/Claim form for payment.
38. **DATE BILLED**: Enter the date the form is mailed using six numerical digits, e.g., mmddyy.
39. **SIGNATURE BLOCK**: The provider, or person authorized by the provider, must sign his/her own name in this signature field and date the form when requesting prior authorization or payment. An original signature in blue or black ink is also required (stamped signatures will not be accepted).

After providing all necessary information on the form please follow these steps:

1. Detach the “Dentist Copy” (page 2, where applicable) and retain for office records.
2. Check page 1 for completeness and legibility.
3. Place attachments, if any, behind the form or the X-ray envelope. Staple them to the back of the form, in the upper right corner. Only staple the attachments once to the form. Excessive staples will delay processing.
4. Mail completed TAR/Claim forms in the large mailing envelopes. Up to 10 forms can be mailed in a single envelope.

Mail completed TAR/Claim forms to:

Medi-Cal Dental
PO Box 15610
Sacramento, CA 95852-0610

TAR/Claim forms used for authorization (as a Treatment Authorization Request) should be mailed separately from TAR/Claim forms requesting payment for services rendered.

5. If submitting two TAR/Claim forms for the same member, staple them together in the upper right corner.

How to Submit a Claim for a Member with Other Coverage

A member having other coverage does not change the prior authorization requirements under Medi-Cal Dental. Medi-Cal Dental will process the prior authorization, and a Notice of Authorization will indicate the amount Medi-Cal Dental would pay as if there were no other coverage.

When completing the claim for payment or NOA, be sure to include the following:

Field 10. ATTACHMENTS:

Include a copy of other coverage carrier's Explanation of Benefits/Readmittance Advice (EOB/RA) or Proof of Denial letter or fee schedule.

Field 13. OTHER DENTAL COVERAGE?

Check “yes,” indicating member has other dental insurance coverage.

Field 34. COMMENTS:

Provide full name and address of other coverage carrier and name, member’s ID for that particular carrier, and group number of the policyholder.

Field 37. OTHER COVERAGE AMOUNT:

Fill in amount paid by other coverage carrier.

How to Submit a TAR for Orthodontic Services

Providers must include a complete orthodontic treatment plan containing:

- Comprehensive Orthodontic Treatment of the Adolescent Dentition (Procedure D8080)
- Periodic Orthodontic Treatment Visits (Procedure D8670)
- Orthodontic Retention (Procedure D8680)

The treatment plan may include:

- Radiographs (Procedure D0210)
- Panoramic radiographic image (Procedure D0330)
- Cephalometric head radiographic image and tracings (Procedure D0340)

Include the quantity, number of visits for active treatment (Procedure D8670). The quantity can vary depending on the type of case and the phase of dentition. Also, indicate the “case type” (e.g., cleft palate or craniofacial anomaly) and “Phase of dentition” (primary, mixed or permanent) in Field 34 (COMMENTS).

Note: Craniofacial anomalies cases may request Pre-Orthodontic Treatment Visits (Procedure D8660 – maximum of 6) and must also submit a separate authorization for these services prior to requesting a complete orthodontic treatment plan.

Reminders:

- Attach HLD Score Sheet (DC-016) to TAR
- Properly pack and box diagnostic casts
- Send diagnostic casts separately, approximately 10 days prior to sending the TAR
- Label diagnostic casts with:
    - Member Name
    - Client Index Number (CIN) or Benefits Identification Card (BIC) number
    - Billing Provider Name
    - Service office National Provider Identifier (NPI) number
    - Centric occlusion marked on cast
- Dry and trim diagnostic casts carefully
- Properly pack and box diagnostic casts
- Send diagnostic casts to the address on TAR or RTD form
- Send diagnostic casts separately, approximately ten days prior to sending the TAR

A Medi-Cal dental orthodontic consultant will determine if the case qualifies for treatment under the Medi-Cal Dental guidelines for orthodontic services.

Please refer to “Section 9: Special Programs” of this Handbook for more information on orthodontic services.

Notice of Authorization (NOA)
(DC-301, Rev. 4/20)

The NOA, a computer-generated form sent to the provider following final adjudication of a TAR/Claim form for prior authorization, is printed with the same information as originally submitted. Presently the NOA is used either to request payment of authorized services or to request a reevaluation of modified or denied services.

Providers may request a reevaluation for denied and/or additional procedures requested in certain instances. Changes to the billed amount or procedures not requiring prior authorization will not be considered.

Reevaluations may be considered when:

- another procedure requiring prior authorization has been requested.
- there is a reversal of denied procedures, e.g., missing radiographs have been submitted.
- there is a complex treatment plan.

Medi-Cal Dental has created the following NOA message when a reevaluation has been requested:

> The submitted changes have been reviewed. Original authorization period still valid.

Medi-Cal Dental has revised the following NOA message when a reevaluation has been re-quested:

> Resubmission not processed. No additional information received. Original authorization period still valid.

To expedite processing and prevent delays or possible denial, please remember to check the box found in the upper right corner of the NOA. Only one reevaluation may be requested per NOA and it must be received prior to the expiration date.

Prior to completing the form, verify that the information printed on the form is correct.

The NOA is printed by Medi-Cal Dental with the following information:

1. Authorized period of time (180 days).
2. member information (except Medi-Cal ID Number).
3. Provider information
4. Procedures allowed, modified, disallowed
5. Allowances
6. Adjudication Reason Codes

Medi-Cal Dental will indicate on the NOA if the services requested are allowed, modified or disallowed. For those allowed services, fill in the appropriate shaded areas on the top portion of the NOA form, including the dates for all services. Submit the completed and

signed form for payment for the services performed. Also, fill in the appropriate shaded areas on a copy and retain this one for office records.

The NOA has a statement printed on the bottom of the form that reads: “NOTE: Authorization does not guarantee payment. Payment subject to member's eligibility.” This statement has been added to remind the dentist to verify the member's eligibility prior to providing services.

Time limitations for billing services provided under Medi-Cal Dental are as follows:

- Six calendar months after the end of the month in which the service is authorized will be considered for full payment (100 percent of the SMA).
- Seven to nine months after the end of the month in which the service is authorized will be considered for payment at 75 percent of the SMA amount.
- Ten to twelve months after the end of the month in which the service is authorized will be considered for payment at 50 percent of the SMA amount.

If the allowed period of time on the NOA has expired and none of the authorized services have been completed, please send the expired NOA back to Medi-Cal Dental so it can be deleted from the automated system. If at a later date authorization for these services is requested and there is an outstanding NOA for the same services, processing delays or denial of services can occur.

Note: If a member's 21st birthday occurs during the authorized period of time, most services may be completed with the exception of orthodontic treatment. (See Section 5 - Manual of Criteria).

Sample Notice of Authorization (NOA)

STAPLE HERE

DO NOT WRITE IN THIS AREA

STAPLE HERE

DHCS Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO CALIFORNIA 95852-0609
Phone (800) 423-0507

NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:
FROM:
TO:

RE-EVALUATION IS REQUESTED ☐ YES

PAGE ____ OF ____

1. MEMBER NAME (LAST, FIRST, M.I.)	3. SEX M F	4. MEMBER BIRTHDATE MO DAY YR	5. MEMBER MEDI-CAL ID. NO.
9. RADIOGRAPHS ATTACHED HOW MANY? CHECK IF YES	10. OTHER ATTACHMENTS CHECK IF YES	11. ACCIDENT/INJURY? EMPLOYMENT RELATED? CHECK IF YES YES	13. OTHER DENTAL COVERAGE? CHECK IF YES 16. CHDP YES	7. MEMBER DENTAL RECORD NO.

23.

BIC Issue Date: _____

EVC #: _____

41. DELETE	26. TOOTH NO. OR LETTER ARCH	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. REASON CODE	33. RENDERING PROVIDER NO.
			1							
			2							
			3							
			4							
			5							
			6							
			7							
			8							
			9							
			10							
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			12							
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			15							
			16							
			17							
			18							
			19							
			20							
			21							
			22							

44. DATE PROSTHESIS ORDERED

43. PROSTHESIS LINE ITEM

- WHEN APPLICABLE, ALL SERVICES SUBMITTED FOR MEMBERS UNDER 21 YEARS OF AGE HAVE BEEN EVALUATED FOR EPSDT CRITERIA.
- ADJUDICATION REASON CODES - SEE PROVIDER HANDBOOK.
- AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO MEMBER ELIGIBILITY.
- AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
- USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

34. COMMENTS

35. TOTAL FEE CHARGED	
46. TOTAL ALLOWANCE	
36. MEMBER SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	

NOTICE OF AUTHORIZATION

- FILL IN SHADED AREA AS APPLICABLE
- SIGN AND RETURN FOR PAYMENT
- MULTIPLE - PAGE NOAs MUST BE RETURNED TOGETHER FOR PAYMENT OR RE-EVALUATION

39. **TREATMENT COMPLETED - PAYMENT REQUESTED**
THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE AND COMPLETE AND THAT 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 _____ ORIGINAL SIGNATURE REQUIRED DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

SIGN ONE COPY AND SEND IT TO MEDI-CAL DENTAL - RETAIN THE OTHER FOR YOUR RECORDS.

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO MEMBER'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.

301 NOA 4/20

Sample

How to Complete the NOA

The shaded fields on the NOA require completion by the dental office. All fields listed below are required unless otherwise stated.

1. **MEMBER NAME (LAST, FIRST, MI)**: Preimprinted by Medi-Cal Dental.
2. Field removed
3. **SEX**: Preimprinted by Medi-Cal Dental.
4. **MEMBER BIRTHDATE**: Preimprinted by Medi-Cal Dental.
5. **MEMBER MEDI-CAL IDENTIFICATION NUMBER**: Enter the member's 14-digit State Recipient Identifier as it appears on the Medi-Cal identification card (Benefits Identification Card, "BIC"). Completion of this field is required.
6. Field removed
7. **MEMBER DENTAL RECORD NO**.: Enter the dental record for the member. This field is optional.
8. Field removed
9. **RADIOGRAPHS ATTACHED? HOW MANY?** Check if "yes" and indicate the number of films enclosed. All radiographs and any attachments should be clearly identified with the member's name and BIC, the date the radiograph was taken, and the provider's name and provider number.
10. **OTHER ATTACHMENTS?** Check "yes" if additional documents are attached to include related correspondence, periodontal charts, operating room reports, or physician's report describing the member's specific medical condition.
    Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
11. **ACCIDENT/INJURY? EMPLOYMENT RELATED?** Check "yes" if the member was in an accident or incurred an injury that resulted in the need for dental services. Additionally, if the member's accident or injury was "Employment Related" check "yes." Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
12. Field removed
13. **OTHER DENTAL COVERAGE?** Check "yes" if the services performed are either fully or partially covered by a private or employer paid dental insurance carrier. The provider must bill the other insurance carrier prior to submitting the NOA form to Medi-Cal Dental. In the "COMMENTS" section (Field 34), furnish the full name and address of the other insurance carrier, and name, BIC, and group number of the policy holder. Attach a copy of the other insurance carrier's Explanation of Benefits, fee schedule or denial letter. See "Section 2: Program Overview" of this Handbook for additional information on other coverage. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
14. Field removed

15. Field removed
16. **CHDP -CHILD HEALTH AND DISABILITY PREVENTION?** Check “yes” if the treatment is related to a previous CHDP screening.
    Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
17. Field removed
18. Field removed
19. Field removed
20. Field removed
21. Field removed
22. Field removed
23. **BIC ISSUE DATE. EVC #:** This area is only used to record the new issue date for Benefits Identification Cards (BICs).
24. Field removed
25. Field removed
26. **TOOTH NO. OR LETTER ARCH**: The tooth number or letter arch here. For permanent supernumerary teeth continue with numbers 33 — 40. For primary supernumerary teeth, continue with letters U — Z.
27. **SURFACES**: Pre imprinted by Medi-Cal Dental. The surface of the tooth being restored as indicated by tooth surface (F=facial, B=buccal, O=occulsal, M=mesial, D=distal, L=lingual).
28. **DESCRIPTION OF SERVICES**: Preimprinted by Medi-Cal Dental. The type of service the provider is authorized to perform (X-rays, teeth cleaning, fillings, etc.).
29. **DATE SERVICE PERFORMED**: Indicate the date the service was performed. Use six numerical digits, e.g., mmddyy.
30. **QUANTITY**: Preimprinted by Medi-Cal Dental. The quantity of the service provided.
31. **PROCEDURE NUMBER**: Preimprinted by Medi-Cal Dental. Enter the CDT 22 procedure code for the service.
32. **FEE**: Preimprinted by Medi-Cal Dental. The fee charged for each rendered service.
33. **RENDERING PROVIDER NO.:** A rendering provider (NPI) number is required in this Field on all TAR/Claim forms and NOAs when requesting payment for dated services. If a rendering provider number (NPI) is not indicated on the NOA, the NOA will be delayed and a RTD will be issued requesting the missing data. If there is more than one dentist or dental hygienist at a service office billing under a single dentist's provider number, enter the NPI of the dentist or dental hygienist **who performed the service**.
34. **COMMENTS**: Use for additional clinical remarks necessary to document treatment or for requested information regarding other coverage, etc. It is helpful to note in this area if additional documentation is attached.
35. **TOTAL FEE CHARGED**: Preimprinted by Medi-Cal Dental. The total dollar amount requested by the provider office on the original TAR.

36. **MEMBER SHARE OF COST AMOUNT**: The dollar amount of the member's share of cost collected by or due from a recipient who has a share of cost obligation. If there is no share of cost, then leave this field blank.
37. **OTHER COVERAGE AMOUNT: FOR PAYMENT CLAIMS ONLY.** The dollar amount of "other coverage" payments the provider has received for the listed procedure. If Field 13 (OTHER DENTAL COVERAGE) is checked "yes," the amount received from the private dental insurance carrier must be entered. The Explanation of Benefits (EOB) or denial letter from the private dental insurance carrier must be attached to the NOA form for payment.
38. **DATE BILLED**: Enter the date the form is mailed using six numerical digits, e.g., mmddyy.
39. **SIGNATURE BLOCK**: The provider, or person authorized by the provider, must sign his/her own name in this signature field and date the form when requesting payment. The signature must be an original signature in blue or black ink. Rubber stamp signatures are not acceptable.

    Additional services not requiring prior authorization may be added to the NOA when submitted for payment. However, radiographs or documentation must be sent with the NOA to justify the additional services. After providing all necessary information on the form, please follow these steps:

    - Sign and date one copy of the NOA. Mail this one to Medi-Cal Dental. Multi-page NOAs should be returned together.
    - Retain the other copy for office records.
    - If radiographs are being submitted, enclose them in the green-bordered X-ray envelope and attach it to the NOA.
    - Mail completed forms in the large, green-bordered envelopes that have been provided. Up to 10 forms can be mailed in a single envelope.

    Mail NOAs to the post office box listed below:

    Medi-Cal Dental
    California Medi-Cal Dental
    PO Box 15609
    Sacramento, CA 95852-0609

40. Field removed
41. **DELETE**: If treatment was not performed, place an "X" in the column corresponding to the treatment not performed. Do NOT strike out the entire line.
42. **ALLOWANCE**: Pre imprinted by Medi-Cal Dental. Reflects the dollar amount Medi-Cal Dental will pay for each procedure.
43. **ADJ. REASON CODE**: Pre imprinted by Medi-Cal Dental. Indicates the adjudication reason code (if applicable).
44. **DATE PROSTHESIS ORDERED**: If an approved prosthesis cannot be delivered, indicate the date the prosthesis was ordered from the dental laboratory.

45. **PROSTHESIS LINE FIELD**: Indicate the number of the line corresponding to procedure billed for the undelivered prosthesis.
46. **TOTAL ALLOWANCE**: Pre imprinted by Medi-Cal Dental. Reflects the dollar amount Medi-Cal Dental will pay for the entire NOA.

Please make sure all applicable areas of the forms are filled in completely and accurately. Any claim service line (CSL) submitted with an invalid procedure code, or a blank procedure code field will be denied, whether submitted electronically or as paper documents. Documents received with a missing or incorrect address or NPI can delay the processing of TARs and claims and increase the possibility that payments may be forwarded to the wrong office.

Reevaluation of the Notice of Authorization (NOA) For Orthodontic Services

Under the orthodontic program, providers may request a reevaluation on a denied NOA for the orthodontic treatment plan only. Reevaluations must be received by Medi-Cal Dental on or before the expiration date (within 180 days).

There are no reevaluations on “exploded” NOAs. An explanation of the term “exploded” is: the submitted Treatment Authorization Request (TAR) will include all requested orthodontic treatments but when Medi-Cal Dental sends the NOAs, the NOAs will be sent individually by procedure code(s). The NOAs will be sent in the following order:

- Comprehensive Orthodontic Treatment of the Adolescent Dentition (Procedure D8080)
- Remaining Treatment Visit NOAs (Procedure D8670) will be sent one per quarter over the course of the treatment
- Orthodontic Retention NOA for upper and lower retainers (Procedure D8680 x 2) will follow upon completion of the active phase of treatment

Providers are reminded:

- A reevaluation may only be requested on a denied NOA for the Orthodontic Treatment Plan only
- Check the “Reevaluation Box” on the NOA
- Medi-Cal Dental must receive the NOA prior to the expiration date
- Attach HLD and all additional documentation to NOA
- Do not sign the NOA
- NOA may only be submitted for reevaluation one time
- See “Section 9: Special Programs” of this Handbook for more information on Orthodontic services

Reevaluations

Only one request for reevaluation per NOA is allowed, and it must be received prior to the expiration date.

To request reevaluation of a NOA, follow these steps:

1. Check the box marked “REEVALUATION IS REQUESTED” at the upper right corner of the NOA.
2. Do not sign the NOA.
3. Include additional documentation and/or enclose radiographs, as necessary.
4. Return to:

   Medi-Cal Dental
   PO Box 15609
   Sacramento, CA 95852-0609

5. After the reevaluation is made, a new NOA will be generated and sent to your office.

If a denial is upheld and another review is wanted, a new TAR must be submitted.

Outstanding Treatment Authorization Requests (TARs)

Since TARs can remain outstanding in the automated system for an extended length of time, Medi-Cal Dental may deny authorization or payment of services based on an outstanding authorization. Medi-Cal Dental may reconsider denial of authorization or payment of services that are duplicated on an outstanding TAR under the following circumstances:

- written notification from the member stating that he or she will not be returning to the original provider's office;
- closure of the original provider's office;
- sale of the original provider's practice;
- death of the original provider;
- refusal of the original provider to return the Notice of Authorization;
- treatment (such as extraction) was provided on an emergency basis by one dentist when authorization for the same treatment was granted previously to a different dentist.

For reconsideration of denial of authorization or payment under these circumstances, please follow these guidelines:

Obtain a written statement from the member that treatment will not be provided by the original dentist.

For an Explanation of Benefits (EOB) showing denial of payment: Attach the member's statement to the EOB and follow the normal procedures for the Claim Inquiry Form.

For a NOA showing denial of treatment authorization: Attach the member's statement and any other supporting documentation to the NOA and submit the NOA with necessary radiographs to obtain reauthorization of the services. Medi-Cal Dental will send the provider office a new NOA showing the allowed services and will void the original TAR.

Notice of Medi-Cal Dental Action

Medi-Cal Dental sends all Medi-Cal dental members and/or their authorized representatives written notification when services that require prior authorization have been denied, modified, or deferred. The notification indicates the status of the Treatment Authorization Request (TAR) and explains why the requested service was denied, modified, or deferred. Members do not receive written notification of approved TARs or services that have been performed. Members are notified of any action taken on a TAR, including, but not limited to, a change from one procedure to another (Replaced and Substituted), denial of a procedure for any reason, and a Resubmission Turnaround Document (RTD) request for more information.

When the dental office prepares a TAR for a member with an authorized representative who is not identified on the BIC card, the representative's name and address should be included in the “Comments” box (Field 34) on page 2 of the Medi-Cal Dental TAR form. This will assist Medi-Cal Dental in identifying cases where the TAR status notification should be sent to a representative and will help with correct address information. Medi-Cal Dental must have a written authorization approving the person designated as the member’s representative.

Members may contact the provider for assistance with inquiries concerning their Notice of Medi-Cal Dental Action notices. Members are sent an enclosed insert, titled Reason for Action Codes, with each Notice of Medi-Cal Dental Action they receive. This insert provides the code descriptions for each Reason for Action Code listed in the member’s notice. To help members better understand the Medi-Cal Dental action taken, providers can match the Reason for Action Code(s) listed in column five of the table in the Notice of Medi-Cal Dental Action against the code descriptions in the Reason for Action Codes insert.

If the provider is unable to answer the member’s questions, please refer them directly to Medi-Cal Dental. A Medi-Cal dental member or authorized representative may call the Telephone Services Center toll-free number at (800) 322-6384 for assistance with inquiries about denied, modified or deferred TARs, including RTD requests.

Sample Notice of Medi-Cal Dental Action

DHCS | Medi-Cal Dental

NOTICE OF MEDI-CAL DENTAL ACTION
THIS IS NOT A BILL

SERVICE OFFICE NAME:

MEDS ID:
DCN:
MRDCN:

PAGE OF
DATE OF REQUEST:
MEMBER NAME:

Medi-Cal Dental has processed your dentist's request for your treatment in accordance with Title 22, California Code of Regulations, Sections 51003, 51307, and the Manual of Criteria. At least one of the items cannot be approved or requires modification. Please refer to the enclosed list for an explanation of the REASON FOR ACTION CODE(S) listed. In addition, specific minimum requirements can be found in the Medi-Cal Dental Provider Handbook, under Section 5 entitled "MANUAL OF CRITERIA" under the specific Procedure Number listed below. A copy may be found at any Medi-Cal dentist's office.

Tooth # or Arch	Treatment Description	Procedure Number	Medi-Cal Dental Action	Reason for Action Code(s) (see enclosed for explanation)

- You can discuss different treatment plans with your dentist to obtain the best care allowable under the Medi-Cal Dental program.
- If you have a question regarding this action, please contact your dentist or Medi-Cal Dental at 1-800-322-6384 for a more detailed explanation.
- If you are dissatisfied with the action described on this notice, you may request a state hearing within 90 days from the Notice Date. Please see the back of this notice for information on filing a hearing.

P.O. Box 15539 • Sacramento, CA 95852-1539 • (800) 322-6384

Sample

IF YOU ARE DISSATISFIED WITH THE ACTION DESCRIBED ON THIS NOTICE, YOU MAY REQUEST A STATE HEARING WITHIN 90 DAYS FROM THE NOTICE DATE.

To Request a Hearing:

SEND BOTH SIDES OF THIS ENTIRE NOTICE TO:
California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

OR

You may call the TOLL-FREE number at the Public Inquiry and Response Unit. 1-800-952-5253 (ASSISTANCE AVAILABLE IN LANGUAGES OTHER THAN ENGLISH)
OR
You may call the TDD toll-free number: 1-800-952-8349

State Regulations:

A copy of Title 22, California Code of Regulations, Sections 50951, 51014.1, and 51014.2, which covers state hearings, is available at your county social services office or local library.

Authorized Representative:

You can represent yourself at the hearing or you can be represented by a friend, lawyer or any other person. You are expected to arrange for the representative yourself. You can obtain the telephone numbers to legal aid organizations by calling the toll-free number of the Public Inquiry and Response Unit or from your local Social Security Office.

I WILL NEED A TRANSLATOR (at no cost to me).
MY LANGUAGE OR DIALECT IS:_____

Sample

Sample Notice of Medi-Cal Dental Action Insert: Reason for Action Codes

DHCS **Medi-Cal Dental**

WHEN APPLICABLE, ALL SERVICES SUBMITTED FOR MEMBERS UNDER 21 YEARS OF AGE HAVE BEEN EVALUATED FOR EPSDT CRITERIA.

REASON FOR ACTION CODES

01 Your eligibility (aid code) covers emergency services only.

02 Information sent by your dentist about your current dental condition does not meet the minimum requirements for approval of this service.

03 The request for dental treatment was changed. This change was based on the information sent by your dentist about your current dental condition or to follow program guidelines.

04 Our records show this service(s), or a similar service(s) was previously approved, paid for, or completed. (For example: In some cases, procedures are limited to once in 12 months or once in five (5) years and cannot be approved again except under special conditions, which must be documented by your dentist.)

05 We are unable to verify your dentist's enrollment in the program on the date the request was received.

06 The service requested by your dental provider, is not a benefit of the program. Please contact your provider for a different treatment plan.

07 You did not appear for a scheduled screening exam or failed to bring existing denture(s) (full or partial) to your appointment. Please contact your dentist to send a new request.

08 Your dentist did not send enough information to allow us to process this request. Please contact your dentist for information about this treatment.

09 X-rays show that the tooth does not meet the requirements for a crown. The tooth may be fixed with a filling.

10 X-rays show that the tooth/teeth may have an infection; please contact your dentist as another service may be needed first.

11 Based on x-rays, chart records and/or information confirmed by your clinical screening exam you do not need a deep cleaning.

12 This service cannot be approved because it is related to a denied procedure in the same treatment plan sent by your dentist.

13 Based on the information from your dentist and/or a clinical screening exam, your current dental condition is stable, and the requested service is not needed at this time.

14 Based on x-rays and/or information confirmed by your clinical screening exam, the tooth/teeth has/have worn down naturally or has been caused by grinding your teeth. The requested service is not a benefit of the program unless there is decay or a broken tooth.

15 X-rays show the tooth is too broken down and cannot be fixed. Your dentist may be able to offer a different treatment.

16 Our records show that the tooth has been fixed with a filling or stainless steel crown.

17 X-rays show the service asked for cannot be approved because gum disease has destroyed the bone around the tooth. Your dentist may be able to offer a different treatment.

18 The minimum requirements for braces could not be verified.

19 A partial denture can be a benefit only when there is a full denture on the opposite arch.

20 Root canal treatment must be satisfactorily done before a crown can be considered.

21 The tooth is not fully formed. Your dentist may be able to offer a different treatment.

22 Treatment is not needed because the x-rays and documentation show that there is no nerve damage.

23 A stayplate can be a benefit only to replace a missing permanent front tooth.

BTN-002 08/20 AUG

24 X-rays show more extractions are needed before the treatment plan can be approved; please contact your dentist.

25 Based on information sent by your dentist, your teeth are in such a poor condition that the requested partial denture is not a benefit under this program.

26 Based on the information sent by your dentist, your teeth are fine and should not be replaced by a full denture.

27 Based on the information sent by your dentist, you do not have a full denture on the opposite arch; therefore, you do not qualify for a metal partial. However, if you are missing front teeth, you qualify for a stayplate.

28 Based on x-rays, documentation, and/ or information received from your screening exam, your teeth and/ or gums are in such poor condition that the requested treatment is not a benefit under this program. Your dentist may be able to offer a different treatment.

29 Your request for dental services was returned to your dental provider for more information. Your provider has 45 days to resubmit the information requested. There is no action needed from you, but you may contact your dentist about this request. A request for a State Hearing is not an option at this time.

30 Fixed bridges are allowable when a medical condition prevents the use of a removable denture.

31 The tooth is not in its normal position and cannot be fixed under this program.

32 Based on information received from a screening exam, your current denture is good at this time.

33 Based on your recent screening exam, a denture is not the right treatment for you. Please contact your dentist for other options.

34 The requested denture is not approved because there are enough teeth remaining in the arch to support the denture.

35 During your screening exam, you said you do not want any dental services at this time or that you want to be seen by another dentist.

36 The number of approved visits has been adjusted because you will be 21 years old before treatment is completed. Please contact your dentist.

37 The tooth is not shown on the submitted x-rays.

38 Based on x-rays and/or information received from your screening exam; you need additional treatment from your dentist before the procedure can be considered.

39 X-rays show there is not enough space for the requested false tooth.

40 This program does not cover braces when baby teeth are still present.

41 Based on x-rays and information received from your screening exam, you grind your teeth. The program does not cover services for this condition.

42 The procedure is not a benefit for a baby tooth or for a baby tooth ready to fall out. Your dentist may be able to offer a different treatment for your condition.

43 The procedure requested will not fix your dental problem. Your dentist may be able to offer a different treatment for your condition.

44 Based on information received from your dentist, the requested service is for cosmetic reasons only. Services for cosmetic purposes only are not a benefit of the program.

45 Your current denture can be fixed by replacing the inner side of the denture.

46 We are unable to verify your eligibility in this program.

47 Your dentist must contact the California Children's Services program before submitting this procedure for payment or approval.

48 EPSDT Services are not a benefit for patients 21 years and older.

49 The EPSDT service(s) requested is not medically necessary.

Resubmission Turnaround Document (RTD) (DC-102, Rev. 10/19)

An RTD is a computer-generated form used by Medi-Cal Dental to request missing or additional information on the TAR/Claim form or NOA submitted by the provider.

The form is divided into two sections:

> **Section "A"** notifies the provider of the specific information found in error on the TAR/Claim form or NOA. Each error in Section "A" is assigned a letter of the alphabet under "field." Section "A" is kept by the provider for office records.
>
> **Section "B"** is the corrected information filled in by the provider. This section is returned to Medi-Cal Dental.

If necessary, a multi-page RTD may be issued for an individual TAR/Claim form or NOA: Return all pages in one envelope.

Upon receipt of the RTD, Medi-Cal Dental matches the RTD with the associated TAR/Claim form or NOA, and the treatment form is then processed.

Note: If the RTD is not returned within the 45-day time limitation, the TAR, Claim or NOA will be denied according to Medi-Cal Dental policies.

Sample Resubmission Turnaround Document (RTD)

RESUBMISSION TURNAROUND DOCUMENT

☐ CLAIM ☐ TAR ☐ NOA

DHCS | Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO CALIFORNIA 95852-0609
Phone (800) 423-0507

IMPORTANT: LISTED IN SECTION "A" ARE ERROR(S) FOUND ON THE CLAIM/TAR/NOA. TO FACILITATE PROCESSING, TYPE OR PRINT THE CORRECT INFORMATION IN THE CORRESPONDING ITEM IN SECTION "B", SIGN AND DATE FORM AND RETURN SECTION "B" (BOTTOM PORTION) TO MEDI-CAL DENTAL. PLEASE RESPOND PROMPTLY, AS PROCESSING CANNOT BE ACCOMPLISHED UNLESS CORRECTIONS ARE RECEIVED BY THE DUE DATE INDICATED. FAILURE TO RESPOND WITHIN THE TIME LIMITATION WILL RESULT IN DENIAL OF SERVICES. IF YOU HAVE ANY QUESTIONS CALL 800-423-0507 FOR ASSISTANCE OR REFER TO YOUR PROVIDER HANDBOOK FOR FURTHER EXPLANATION.

BILLING PROVIDER NAME MAILING ADDRESS CITY, STATE, ZIP CODE	MEDI-CAL PROVIDER NO.	NOTICE	PAGE OF PAGES
		RTD ISSUE DATE	RTD DUE DATE

PATIENT NAME	PATIENT MEDICAL I.D. NUMBER	PATIENT DENTAL RECORD NO.	BEGINNING DATE OF SERVICE	AMOUNT BILLED	DOCUMENT CONTROL NO.

ITEM	INFORMATION BLOCK	CLAIM FIELD NO.	CLAIM LINE	SUBMITTED INFORMATION	PROCEDURE CODE	ERROR CODE	ERROR DESCRIPTION

Sample

RETAIN THIS PORTION

DETACH ALONG THIS PERFORATION

DOCUMENT CONTROL NUMBER • FOR MEDI-CAL DENTAL USE ONLY

BILLING PROVIDER NAME

MEDI-CAL PROVIDER NAME

PATIENT NAME

PATIENT MEDI-CAL I.D. NUMBER

This is to certify that the corrected information is true, accurate, and complete and that 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.

IF REQUESTED AFFIX P.O.E. LABEL(S) IN THIS SPACE. THIS SPACE MAY BE USED FOR COMMENTS.

MEDI-CAL DENTAL USE ONLY

DCN CLAIM TYPE PAGE OF PAGES

SUBMITTED INFORMATION	CLAIM FIELD NO.	CLAIM LINE	ERROR CODE	CORRECT INFORMATION

CORRECTED INFORMATION MUST BE ENTERED ON THE SAME LINE AS THE ERRORS SHOWN IN SECTION "A".

RETAIN THIS PORTION TO: **MEDI-CAL DENTAL** P.O. BOX 15609, SACRAMENTO, CA 95852-0609

How to Complete the RTD

Section "A"

The information in Section "A" is computer-generated by Medi-Cal Dental: it is retained by the provider.

The appropriate box (i.e. CLAIM, TAR, or NOA) will be checked to indicate the type of document submitted.

Note: Please read instructions carefully and verify the information in Section "A" is correct.

1. **BILLING PROVIDER NAME AND MEDI-CAL PROVIDER NUMBER**: As it appears on the document submitted by the provider's office.
2. **MAILING ADDRESS**: As it appears on the document submitted.
3. **CITY, STATE, ZIP CODE**: As it appears on the document submitted.
4. **PAGE __ OF __ PAGES**: A multi-page RTD may be issued for an individual TAR/ Claim form or NOA. Return all pages of the RTD in one envelope.
5. **RTD ISSUE DATE**: The RTD issue date. The RTD must be returned within 45 days of the RTD issue date.
6. **RTD DUE DATE**: The response due date. If not received by this date, the TAR, claim, or NOA will be denied.
7. **PATIENT NAME**: As it appears on the document submitted.
8. **PATIENT MEDI-CAL I.D. NUMBER**: As it appears on the document submitted.
9. **PATIENT DENTAL RECORD NUMBER**: As it appears on the document submitted.
10. **BEGINNING DATE OF SERVICE**: As it appears on the document submitted.
11. **AMOUNT BILLED**: As it appears on the document submitted.
12. **DOCUMENT CONTROL NO**.: The DCN assigned to the document submitted.
13. **ITEM**: The letter of the alphabet assigned by the computer to identify the line in Section "B" where the "Correct Information" should be entered.
14. **INFORMATION BLOCK**: The exact name of the field in question on the claim, TAR, or NOA.
15. **CLAIM FIELD NO**.: Indicates number corresponding to the information block on the claim, TAR, or NOA.
16. **CLAIM LINE**: The line number on the claim, TAR, or NOA.
17. **SUBMITTED INFORMATION**: The description of the incorrect information submitted by the provider's office.
18. **PROCEDURE CODE**: Procedure codes as reported on the claim, TAR or NOA.
19. **ERROR CODE**: A code identifying the error that has been made on the claim, TAR or NOA.
20. **ERROR DESCRIPTION**: A description of the error that has been made on the claim, TAR or NOA.

Section “B”

This section is completed by the provider and returned to Medi-Cal Dental.

1. **CORRECT INFORMATION**: Enter the correct information on the appropriate line in Section “B” corresponding to the information found in error in Section “A.”
2. **SIGNATURE/DATE BLOCK**: The provider, or person authorized by the provider, must sign and date the form prior to its return. Lack of signature will result in disallowance of the document. Rubber stamp signatures are not acceptable.
3. **P.O.E./COMMENTS BLOCK**: This area may be used for any comments.

   Return the completed RTD to:

   Medi-Cal Dental
   California Medi-Cal Dental
   PO Box 15609
   Sacramento, CA 95852-0609

Claim Inquiry Form (CIF)
(DC-003, Rev. 10/19)

The Claim Inquiry Form (CIF) is used to:

- Inquire about the status of a Treatment Authorization Request (TAR) or Claim
- Request re-evaluation of a modified or denied claim or Notice of Authorization (NOA) for payment

Medi-Cal Dental will respond to a CIF with a Claim Inquiry Response (CIR). Use a separate CIF for each claim, TAR, or NOA in question. Please see “Claim Inquiry Response (CIR)” on page 6-33 for more information about CIRs.

CIF Tracer

A CIF tracer is used to request the status of a TAR or claim. Providers should wait one month before submitting a CIF Tracer to allow enough time for the document to be processed. If after one month, the claim or TAR has not been processed or has not appeared in the “Documents In-Process” section of the Explanation of Benefits (EOB), then a CIF tracer should be submitted.

Claim Re-evaluations

A CIF claim re-evaluation is used to request the re-evaluation of a modified or denied claim or NOA. Providers should wait until the status of a processed claim appears on the EOB before submitting a CIF for re-evaluation. A response to the re-evaluation request will appear on the EOB in the “Adjusted Claims” section.

Claim re-evaluations must be received within six months of the date on the EOB. Providers should submit a copy of the disallowed or modified claim or NOA plus any additional radiographs or documentation pertinent to the procedure under reconsideration.

Note: Do not use the CIF to request a first level appeal. Inquiries using the CIF are limited to those reasons indicated on the form. Any other type of inquiry or request should be handled by calling the Telephone Service Center at (800) 423-0507.

Sample Claim Inquiry Form (CIF)

CLAIM INQUIRY FORM

DHCS | Medi-Cal Dental
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

IMPORTANT

Before submitting a CIF:

- Allow one month for the status of the document to appear on your Explanation of Benefits (E.O.B.)
- Type or print all information
- Use the appropriate x-ray envelope and attach to this form
- See your Provider Handbook for detailed instructions
- For clarification call MEDI-CAL DENTAL

1	BILLING PROVIDER NAME: ADAMS, JAMES DDS	2 MEDI-CAL PROVIDER NUMBER: XXXXXXXXXX
3	MAILING ADDRESS: 30 MAIN STREET	TELEPHONE NUMBER: (XXX) XXX-XXXX
4	CITY, STATE: ANYTOWN, CA	ZIP CODE: XXXXX-XXXX

USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY.

5	PATIENT NAME (LAST, FIRST, M.I.)		DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION) 6
7	PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NUMBER (OPTIONAL) 8	DATE BILLED 9

INQUIRY REASON - CHECK ONLY ONE BOX

10

CLAIM/TAR TRACER ONLY

Please advise status of:

- ☐ Claim for Payment. Attach a copy of form Date of Service _____ .
- ☐ Treatment Authorization Request (TAR). Attach a copy of form.

CLAIM RE-EVALUATION ONLY

- ☐ Please re-evaluate modification/denial of claim for payment. I have attached all necessary radiographs and/or documentation.

11

REMARKS (Corrections or Additional Information)

12

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT 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.

SIGNATURE _____ DATE _____

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

FOR MEDI-CAL DENTAL USE ONLY

OPER. I.D. _____

ACTION CODE _____

DC 003 (R 10/19)

Sample

How to Complete the CIF

Use one CIF for each Claim or NOA. Please print or type all information:

1. **BILLING PROVIDER NAME**: Enter the billing provider's name in either the “doing business as” format, such as HAPPY TOOTH DENTAL CLINIC, or in the last-name, first-name, middle-initial, title format, e.g., SMITH, JOHN J., DDS. This information should be consistent with that used when filing state and federal taxes.
2. **MEDI-CAL PROVIDER NUMBER**: Enter the Billing Provider Number (NPI). NOTE: The Provider Number must be present and correct on all forms.
3. **MAILING ADDRESS AND TELEPHONE NUMBER**: Enter the billing provider service office address where treatment is rendered. A service office address should be a street address, including city, state, and zip code. A post office box cannot be used as a service office; however, it is acceptable in rural areas only to use a route number with a post office box number.

   If the service office address is different from the address where payment is received, then notify Medi-Cal Dental so payment can be directed to the appropriate location.

   It is important to include the telephone number of the service office, including area code, so Medi-Cal Dental can contact the provider if questions arise while processing the documents.
4. **CITY, STATE, ZIP CODE**: Enter the city, state, and zip code where the service office is located.
5. **PATIENT NAME**: Enter the member's last name, first name, and middle initial.
6. **DOCUMENT CONTROL NUMBER (CLAIM REEVALUATION ONLY)**: Enter the Document Control Number of the document in question. If you are inquiring about multiple claims submit one CIF only for each document in question.
7. **PATIENT MEDI-CAL ID NUMBER**: Enter the BIC or Client Index Number (CIN).
8. **PATIENT DENTAL RECORD NUMBER (OPTIONAL)**: If the provider assigns a Dental Record Number or Account Number to a member, enter the assigned number that will be referenced on any subsequent correspondence from Medi-Cal Dental.
9. **DATE BILLED**: Enter the date the claim or the TAR was originally mailed to Medi-Cal Dental.
10. **INQUIRY REASON - CHECK ONLY ONE BOX**: Indicate if this inquiry is seeking the status of a TAR or Claim (“tracer”) or is requesting a reevaluation of a claim.
11. **REMARKS**: Use this area to provide any additional information needed to justify the inquiry being made. Include a copy of the claim, TAR, or NOA in question and any appropriate documentation, radiographs, and photos.
12. **SIGNATURE AND DATE**: The provider, or person authorized by the provider, must sign and date the form using blue or black ink. Rubber stamp signatures are not acceptable.

    Mail the form to:

Medi-Cal Dental
California Medi-Cal Dental
PO Box 15609
Sacramento, CA 95852-0609

Claim Inquiry Response (CIR)

Upon resolution of the Claim Inquiry Form (CIF) seeking the status of a TAR or Claim Medi-Cal Dental will issue a Claim Inquiry Response (CIR). The CIR is a computer-generated form used to explain the status of the TAR or Claim.

When the CIR is received, it will be printed with the same information submitted by the provider's office with the following information:

- member name
- member Medi-Cal identification number
- member Dental Record or account number, if applicable
- Document Control Number
- the date the services were billed on the original document.

The section entitled "IN RESPONSE TO YOUR
MEDI-CAL DENTAL INQUIRY" will contain a status code and a typed explanation of that code. The status codes are listed in "Section 7: Codes" of this Handbook.

Sample Claim Inquiry Response (CIR)

MEDI-CAL DENTAL
P.O. BOX 15609
SACRAMENTO, CA 95852-0609
(800) 423-0507

CORRESPONDENCE REFERENCE NUMBER • FOR MEDI-CAL DENTAL USE ONLY
XXXXXXXXXXX

CLAIM INQUIRY RESPONSE

BILLING PROVIDER NAME / ADDRESS	MEDI-CAL PROVIDER NUMBER
ADAMS, JAMES DDS	1234567891
30 CENTER STREET	TELEPHONE NUMBER
ANYTOWN CA 95814-0000	(XXX)XXX-XXXX

PATIENT NAME	DOCUMENT CONTROL NO.
LAST, FIRST	XXXXXXXXXXX

PATIENT MEDI-CAL I.D. NO.	PATIENT DENTAL RECORD NUMBER	DATE BILLED
XXXXXXXXX		

IN RESPONSE TO YOUR DENTI-CAL INQUIRY

STATUS CODE	EXPLANATION
02	CLAIM IN PROCECSS; AWAITING FINAL ADJUDICATION

Sample

ADDITIONAL EXPLANATION

BY: 0XX

DATE: 09/15/09

Checklists

Before submitting a TAR, claim, or NOA to Medi-Cal Dental for payment or authorization, follow this checklist:

1. **Submission for Claim (Payment) or TAR (Authorization)**
   Have you...
   a. Entered the NPI of the rendering provider who provided the services?
   b. completed an original TAR/Claim form?
   c. listed the date services were performed (if applicable)?
   d. indicated the place of service where the procedure was administered?
   e. attached radiographs/photographs?
   f. included any remarks or attachments necessary to document this payment/authorization request?
   g. affixed any paper attachments on a 8.5 x 11 piece of paper?
   h. placed any attachments behind the forms and stapled just once in the upper right-hand corner?
   i. submitted only one-sided attachments?
   j. provided the appropriate signature and date in the signature block?
2. **Submission for NOA (For Payment).**
   Have you...
   a. listed the date of service?
   b. checked the “delete” column for services not performed?
   c. indicated any additions not requiring prior authorization?
   d. included any necessary radiographs/photographs or documentation?
   e. filled in all shaded areas, if applicable?
   f. affixed each paper attachment to an 8.5 x 11 piece of paper?
   g. placed any attachments behind the forms and stapled just once in the upper right-hand corner?
   h. submitted only one-sided attachments?
   i. provided the appropriate signature and date in the signature block?

3. **Submission for NOA (For Reevaluation)**
   Have you...
   a. checked “Reevaluation is Requested” box at upper right corner?
   b. included radiographs/photographs or other documentation?
   c. enclosed your NOA in the appropriate mailing envelope?

Reminders

1. **Diagnostic Casts**

   Diagnostic casts are only for the evaluation of orthodontic benefits. Diagnostic casts submitted for all other procedures (crowns, prosthetics, etc.) will be discarded unless Medi-Cal Dental specifically requested the models to evaluate the claim or authorization request.

   Diagnostic casts are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment.

   As diagnostic casts are not returned, please do not send originals.

2. **Paper Copies and Prints of Digitized Radiographs**

   Paper copies and prints of digitized radiographs should properly identify the member, the date the radiograph was originally taken, and the teeth/area in question. If not properly labeled, this could lead to processing delays as well as denial of treatment.

   Paper copies and digitized prints of radiographs must conform to the following specifications:

   a. They must be properly dated with the mmddyy the radiograph was originally taken. This date must be clearly discernible from other dates appearing on the same copy such as the date the copy was made or printed, or dates of previously stored digitized images.

   b. They must be properly labeled with both the member’s name and the provider’s name.

   c. If the individual teeth are not otherwise identified, copies or digitized prints of full mouth series radiographs and panographic films must be labeled “right” and “left.” Copies of individual films or groups of films less than a full mouth series, should have the individual tooth numbers clearly identified.

   d. They must be of diagnostic quality. Many of the copies/prints Medi-Cal Dental receives have poor image quality as a result of poor density, contrast, sharpness, or resolution, and are, therefore, non-diagnostic. The image size should be the size of a standard radiographic film or larger. By reducing the image to be

smaller than the size of a standard radiographic film, the diagnostic quality is compromised.

e. More than four sheets of paper are not acceptable

Providers should review copies/prints before submitting to Medi-Cal Dental to ensure the images are of diagnostic quality.

3. State–Approved Forms.

Medi-Cal Dental will only accept original
State-approved forms. No duplicates or photocopies will be accepted or processed.

Time Limitations for NOAs

If the allowed period of time on the NOA has expired and none of the authorized services have been completed, send the expired NOA back to Medi-Cal Dental so it can be deleted from the automated system. If at a later date authorization for these services is requested and there is an outstanding NOA for the same services, processing delays or denial of services can occur.

Justification of Need for Prosthesis
(DC054, Rev 02/24)

The Justification of Need for Prosthesis Form (DC054) is designed to provide complete and detailed information necessary for screening and processing prosthetic cases. This form is required when submitting a Treatment Authorization Request (TAR) for complete dentures, immediate dentures (when immediate dentures are rendered in conjunction with an opposing complete denture or partial removable prosthesis), resin base partial dentures, cast metal framework partial dentures, and complete overdentures (Procedures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5863, D5865).

Providers should document specific information describing the condition of the member's oral condition **and** the condition of any existing prosthetic appliances. Documentation must include:

- both arches;
- missing teeth;
- teeth to be extracted;
- teeth being replaced by the requested partial prosthesis (excluding third molars);
- teeth being clasped (applies to cast framework partial or resin base partial);
- the condition of the soft tissue and hard tissue, e.g., soft tissue inflammation, palatal torus, mandibular tori, atrophied ridge, large fibrous tuberosity, hyperplastic tissue, etc.

It is the provider's responsibility to document conditions that Medi-Cal Dental will need for determining the member's need for the initial placement or replacement of a prosthesis as well as their ability to adapt to a prosthesis.

If a provider fails to submit a Justification of Need for Prosthesis Form, Medi-Cal Dental will issue an RTD for the required form, which will delay processing of the request. If the information on the Justification of Need for Prosthesis is incomplete or contradictory, the requested prosthetic appliance(s) will be denied.

The Justification of Need for Prosthesis Form is provided and may be ordered from the Medi-Cal dental forms supplier free of charge. A sample and instructions for completing the form are as follows:

Sample Justification of Need for Prosthesis Form

JUSTIFICATION OF NEED FOR PROSTHESIS

Complete Dentures - Resin Base Partial Dentures - Cast Metal Framework Partial Dentures

This form is to be completed by the dentist providing treatment. Submit this form with the associated TAR.

1 PATIENT: _____ 2 DATE: _____

ADDRESS BOTH ARCHES -- COMPLETE EACH APPROPRIATE SECTION *(TYPE OR PRINT CLEARLY)*

Checked shaded boxes (e.g. ☒ Yes) require Additional Comments below and may require submission of supporting documentation.

3 MAXILLARY ARCH	MANDIBULAR ARCH
Appliance Requested: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD	Appliance Requested: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD
☐ Member has never had a maxillary prosthetic appliance	☐ Member has never had a mandibular prosthetic appliance
4 Has existing appliance: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD Age of appliance? _____ Wears appliance? ☐ Yes ☐ No	Has existing appliance: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD Age of appliance? _____ Wears appliance? ☐ Yes ☐ No
5 Reason for replacement of maxillary appliance: (Check all boxes that apply) ☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework ☐ Extraction of additional teeth ☐ Other _____	Reason for replacement of mandibular appliance: (Check all boxes that apply) ☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework ☐ Extraction of additional teeth ☐ Other _____
Replacement maxillary appliance is needed due to one of the following: Catastrophic Loss? ☐ Yes ☐ No See footnote i. Surgical loss of oral-facial structure? ☐ Yes ☐ No See footnote ii. Denture no longer serviceable? ☐ Yes ☐ No See footnote iii. Significant medical condition? ☐ Yes ☐ No See footnote iv. Non-catastrophic loss? ☐ Yes ☐ No See footnote v.	Replacement mandibular appliance is needed due to one of the following: Catastrophic Loss? ☐ Yes ☐ No See footnote i. Surgical loss of oral-facial structure? ☐ Yes ☐ No See footnote ii. Denture no longer serviceable? ☐ Yes ☐ No See footnote iii. Significant medical condition? ☐ Yes ☐ No See footnote iv. Non-catastrophic loss? ☐ Yes ☐ No See footnote v.

6 Edentulous: ☐ Maxillary ☐ Mandibular

✕ **Block out missing teeth**	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
○ **Circle teeth to be extracted**	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

7

MAXILLARY ARCH	MANDIBULAR ARCH
Teeth being replaced: _____	Teeth being replaced: _____
Teeth being clasped: _____	Teeth being clasped: _____

Does the patient want the requested services? ☐ No ☐ Yes

Does health condition of the patient limit dental adaptability? ☐ No ☐ Yes

8 **ADDITIONAL COMMENTS PERTAINING TO APPLIANCES/TREATMENT PLAN:** _____

9 **Provider Signature:** _____

10

i. Circumstances beyond the control of the patient: For a patient that submits a request to replace the appliance based on circumstances beyond their control, those circumstances can be demonstrated by documentation of all of the following: (1) a demonstration of continued medical necessity; (2) an explanation of the circumstances surrounding the loss which clearly explains how the loss occurred and why the loss was beyond the control of the patient; and (3) a clear explanation of the remedial measures the patient will take to safeguard against subsequent loss. Where loss from an activity wherein there was involvement from a fire department agency, law enforcement agency, or other governmental agency, documentation should include a copy of the official public service agency report, if such a report is relevant and available.

ii. A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure.

iii. The removable prosthesis is no longer serviceable as determined by a clinical screening dentist.

iv. Dentures no longer fit due to significant medical condition. Documentation from the patient's physician supporting the medical necessity of early replacement and a letter from the dentist stating that the existing denture cannot be made functional.

v. A non-catastrophic loss or misplacement may be granted twice per lifetime. Documentation must include an explanation of preventive measures instituted to alleviate the need for further replacement. Additional requests, beyond the two lifetime exceptions shall be submitted as procedure code D5899 and will be considered on a case by case basis.

DC054 (Rev 02/24) ← **Current Version (02/24)**

SAMPLE

How to Complete the Justification of Need for Prosthesis Form

1. **PATIENT NAME**: Enter the member's name exactly as it appears on the Medi-Cal BIC.
2. **DATE**: Enter the date the member was evaluated.
3. **APPLIANCE REQUESTED**: Enter the type of prosthetic appliance requested on the Treatment Authorization Request (TAR).
4. **EXISTING APPLIANCE**: Enter the type of prosthetic appliance that the member has or had (regardless of the condition of the appliance or whether the appliance has been lost, stolen, or discarded). If the member has never had any type of prosthetic appliance, check the corresponding box.

   Indicate whether the member wears the existing appliance and the age of the appliance that the member has (or had). Where loss from an activity wherein there was involvement from a fire department agency, law enforcement agency, or other governmental agency, documentation should include a copy of the official public service agency report, if such a report is relevant and available. If the prosthetic appliance has been lost in a certified facility or hospital, document the date of the incident and the circumstances of the loss. If needed, use the space in the lower part of the Justification of Need for Prosthesis Form for documenting details of the loss.

5. **REASON FOR REPLACEMENT OF EXISTING APPLIANCE**: Document the reason the existing appliance needs to be replaced. Check the boxes that apply. If needed, use the space in the lower part of the Justification of Need for Prosthesis Form for documenting details.

   Reminder: When requesting a prosthetic appliance for only one arch, the opposing arch must also be evaluated and addressed as a comprehensive treatment plan.

6. **MISSING TEETH**: Use an "X" to block out missing teeth on the numerical diagram of the dentition. If teeth are to be extracted, circle the appropriate tooth numbers. If the arch is edentulous, check the corresponding box.

7. **CAST FRAMEWORK PARTIAL OR RESIN BASE PARTIAL**: Indicate the teeth being replaced by the requested appliance and the teeth being clasped.

   Reminder: Please submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.

8. **ADDITIONAL COMMENTS PERTAINING TO TREATMENT PLAN:** Use this section for additional comments/documentation specific to the requested treatment. Some examples include:

a. **NATURAL TEETH BEING RETAINED**: If teeth are being retained in the arch(es), indicate the treatment plan for the remaining teeth (root canals, periodontal treatment, restorative, crowns, etc.).
b. **DOES THE PATIENT WANT REQUESTED SERVICES?** After discussing the proposed treatment plan with the member, indicate whether the member wants the proposed services.
c. **DOES HEALTH CONDITION OF PATIENT LIMIT ADAPTABILITY?** Indicate any conditions that might limit the adaptability of the member to wear a prosthetic appliance. Document if the condition is temporary or permanent.
d. **CONVALESCENT CARE:** If the member resides in a convalescent facility, document facility staff comments regarding the resident's ability to benefit by or adapt to the requested treatment. The TAR should include the facility name, address, and phone number.

9. **SIGNATURE**: The dentist completing the form must sign the form**.**
10. **EXCEPTIONS**: DHCS provides complete and partial dentures as a covered benefit once in a five-year period. When adequately documented, certain exceptions shall apply to this five-year period. Use Section 8 to include additional comments/documentation specific to the requested treatment.

Sample Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet (DC-016, Rev 09/18)

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORE SHEET

(You will need this score sheet and a Boley Gauge or a disposable ruler)

Provider **Patient**

Name:_____ **Name:**_____

Number:_____

Date:_____

- Position the patient's teeth in centric occlusion.
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- ENTER SCORE '0' IF THE CONDITION IS ABSENT

CONDITIONS #1 – #6A ARE AUTOMATIC QUALIFYING CONDITIONS **HLD Score**

1. Cleft palate deformity (See scoring instructions for types of acceptable documentation)
   Indicate an 'X' if present and score no further..... _____
2. Cranio-facial anomaly (Attach description of condition from a credentialed specialist)
   Indicate an 'X' if present and score no further..... _____
3. Deep impinging overbite **WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE. TISSUE LACERATION AND/OR CLINICAL ATTACHMENT LOSS MUST BE PRESENT.**
   Indicate an 'X' if present and score no further..... _____
4. Crossbite of individual anterior teeth **WHEN CLINICAL ATTACHMENT LOSS AND RECESSION OF THE GINGIVAL MARGIN ARE PRESENT**
   Indicate an 'X' if present and score no further..... _____
5. Severe traumatic deviation. (Attach description of condition. For example: loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology.)
   Indicate an 'X' if present and score no further..... _____

6A. Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties. Indicate an 'X' if present and score no further ..... _____

THE REMAINING CONDITIONS MUST SCORE 26 OR MORE TO QUALIFY

6B. Overjet equal to or less than 9 mm..... _____

7. Overbite in mm ..... _____

8. Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm ..... _____ x 5 = _____

9. Open bite in mm ..... _____ x 4 = _____

IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE SAME ARCH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT COUNT BOTH CONDITIONS.

10. Ectopic eruption (Identify by tooth number, and count each tooth, excluding third molars) _____ (tooth numbers) _____ (total) x 3 = _____

11. Anterior crowding (Score one for MAXILLA, and/or one for MANDIBLE) _____ (maxilla) _____ (mandible) _____ (total) x 5 = _____

12. Labio-Lingual spread in mm ..... _____

13. Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar. No score for bi-lateral posterior crossbite) ..... Score 4 _____

AUTHORIZATION OF SERVICES IS BASED ON MEDICAL NECESSITY. IF A PATIENT DOES NOT HAVE ONE OF THE SIX AUTOMATIC QUALIFYING CONDITIONS OR DOES NOT SCORE 26 OR ABOVE, THE PATIENT MAY STILL BE ELIGIBLE FOR THESE SERVICES BASED ON EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) CRITERIA NECESSARY TO CORRECT OR AMELIORATE THE PATIENT'S CONDITION. FOR A FURTHER EXPLANATION OF EPSDT CRITERIA, PLEASE SEE THE ORTHODONTICS SECTION OF THE CALIFORNIA MEDI-CAL DENTAL PROGRAM PROVIDER HANDBOOK.

DC016 (R 09/18)

Sample

How to Complete the HLD Index Scoresheet

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION
SCORING INSTRUCTIONS

The intent of the HLD index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose 'malocclusion.' All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering '0.' (Refer to the attached score sheet.)

The following information should help clarify the categories on the HLD Index:

1. **Cleft Palate Deformity:** Acceptable documentation must include at least one of the following: 1) diagnostic casts; 2) intraoral photograph of the palate; 3) written consultation report by a qualified specialist or Craniofacial Panel) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)

2. **Cranio-facial Anomaly:** (Attach description of condition from a credentialed specialist) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)

3. **Deep Impinging Overbite:** Indicate an 'X' on the score sheet when lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

4. **Crossbite of Individual Anterior Teeth:** Indicate an 'X' on the score sheet when clinical attachment loss and recession of the gingival margin are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

5. **Severe Traumatic Deviation:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Indicate an 'X' on the score sheet and attach documentation and description of condition. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)

6A **Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties:** Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and it's corresponding lower central or lateral incisor. If the overjet is greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) is greater than 3.5mm with masticatory and speech difficulties, indicate an 'X' and score no further. (This condition is automatically considered to be a handicapping malocclusion without further scoring. Photographs shall be submitted for this automatic exception.)

6B **Overjet equal to or less than 9mm:** Overjet is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter and entered on the score sheet.

7. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. ('Reverse' overbite may exist in certain conditions and should be measured and recorded.)

8. **Mandibular Protrusion (reverse overjet) equal to or less than 3.5mm:** Mandibular protrusion (reverse overjet) is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter. Enter on the score sheet and multiply by five (5).

9. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from incisal edge of a maxillary central incisor to incisal edge of a corresponding mandibular incisor, in millimeters. The measurement is entered on the score sheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

10. **Ectopic Eruption:** Count each tooth, excluding third molars. Each qualifying tooth must be more the 50% blocked out of the arch. Count only one tooth when there are mutually blocked out teeth. Enter the number of qualifying teeth on the score sheet and multiply by three (3). If anterior crowding (condition #11) also exists in the same arch, score the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

11. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Score one (1) for a crowded maxillary arch and/or one (1) for a crowded mandibular arch. Enter total on the score sheet and multiply by five (5). If ectopic eruption (condition #10) exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

12. **Labio-Lingual Spread:** A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the score sheet.

13. **Posterior Unilateral Crossbite:** This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet. **NO SCORE FOR BI-LATERIAL CROSSBITE.**

Sample

Explanation of Benefits (EOB)

The Explanation of Benefits (EOB) is a
computer-generated statement which accompanies each check sent to Medi-Cal dental providers. It lists all paid and denied claims that have been adjudicated or adjusted during the payment cycle, as well as
non-claims specific information. Claims and TARs that have been in process over 18 days are also listed.

Lost/Misplaced EOBs

Providers are issued an EOB each week which lists, in detail, all activity on documents for accounting and tracking purposes. Listed on the weekly EOB are all paid claims, adjustments, and current status of pending documents. In addition, the EOB contains seminar information, accounts payable and receivable activity, and notification of electronic funds transfer information.

Each service office with claim activity receives an EOB which should be used for payment posting, account balancing, and monitoring the progress of documents in process as they go through the system. Service offices managed through corporate offices should have internal procedures in place to ensure they receive the most current information relative to their submissions, i.e., FAX, scanned email, etc.

Lost or misplaced EOBs can be reprinted. Please submit your request in writing, including your provider number and the EOB issue date to:

Medi-Cal Dental
Attn: Provider Services General Correspondence
PO Box 15609
Sacramento, CA 95852-0609

Sample Explanation of Benefits (EOB)

EXPLANATION OF BENEFITS

1 LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

2 LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

CALIFORNIA MEDI-CAL DENTAL
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

3 PROVIDER No

5 CHECK No

6 DATE:

7 PAGE NO.

4

8 STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

9 BENEFICIARY NAME	10 MEDI-CAL I.D. NO.	11 BENE ID	12 SEX	13 BIRTH DATE

C DOCUMENT CONTROL NO. 14	TOOTH CODE 15	PROC. CODE 16	DATE OF SERVICE 17	STA-TUS 18	REASON CODE 19	AMOUNT BILLED 20	ALLOWED AMOUNT 21	SHARE OF COST 22	OTHER COVERAGE 23	AMOUNT PAID 24

Sample

25 CLAIMS SPECIFIC		26 NON CLAIMS SPECIFIC			27
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT

How to Read the EOB

Following is an explanation of each item shown on the sample EOB. Each item is numbered to correspond with those numbers on the sample EOB.

1. **REFERENCE LINES PRECEDED BY A "B"**: contains member's information.
2. **REFERENCE LINES PRECEDED BY A "C"**: contains claim information for the listed member.
3. **PROVIDER NO.**: The billing provider's NPI.
4. **PROVIDER'S NAME AND ADDRESS**: The provider's name and billing address.
5. **CHECK NO.**: Number of the check issued with the EOB.
6. **DATE**: Date EOB was issued.
7. **PAGE NO.**: Page number of the EOB.
8. **STATUS CODE DEFINITION**: The status code used to identify each claim line. "P" = Paid, "D" = Denied, "A" = Adjusted.
9. **PATIENT NAME**: Each member is listed once per category.
10. **MEDI-CAL I.D. NO.**: The member 's Medi-Cal identification number.
11. **BENE ID**: The member's BIC or CIN.
12. **SEX**: The sex code for each member, "M" = male, "F" = female.
13. **BIRTHDATE**: Birthdate of each member.
14. **DOCUMENT CONTROL NUMBER (DCN)**: The number assigned to each claim by Medi-Cal Dental.
15. **TOOTH CODE**: Lists the tooth number, letter, arch or quadrant on which the procedure was performed.
16. **PROC. CODE**: The code listed on a claim line that identifies the procedure performed. This code may be different from the procedure code submitted on the TAR/Claim form because the procedure code may have been modified by a professional or paraprofessional in compliance with the Manual of Dental Criteria for successful adjudication of the claim.
17. **DATE OF SERVICE**: The date the service was performed.
18. **STATUS**: Identifies the status of each claim line. The status codes are explained in "Section 7: Codes" of this Handbook.
19. **REASON CODE**: The code explains why a claim was either paid at an amount other than billed; changed; altered during processing; or denied. The reason codes and a written explanation of each one are printed on the EOB.
20. **AMOUNT BILLED**: The amount billed for each claim line.
21. **ALLOWED AMOUNT**: The amount allowed for each claim line; this amount is the lesser of the billed amount or the amount allowed by the Schedule of Maximum Allowances.
22. **SHARE OF COST**: The amount the member paid towards a share of cost obligation.
23. **OTHER COVERAGE**: The amount paid by another carrier or by Medicare.
24. **AMOUNT PAID**: The total amount paid to a provider after deductions, if applicable, as shown in numbers 22 and 23.

25. **CLAIMS SPECIFIC**: Only printed on the last page of the EOB. These amounts are the totals for all adjudicated claim lines listed on the EOB.
26. **NON-CLAIMS SPECIFIC**: The (a) payables amount; (b) levy amounts, (c) accounts receivable amounts. Only printed on the last page of the EOB.
27. **CHECK AMOUNT**: The amount of the check that accompanies this EOB.

Sample Paid Claim, Levy

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER
No **XXXXXXXXXX**

CHECK
No **XXXXXXXX**

TAX ID NO:
xxxxxxxxx-

DATE: **mm/dd/yy** **PAGE NO.** **x**
OF **x**

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B BENEFICIARY NAME | MEDI-CAL I.D. NO. | BENE ID | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STA-TUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

** IF THERE IS A LACK OF RECENT DENTI-CAL ACTIVITY FOR THIS SERVICE OFFICE, THE OUTSTANDING
** BALANCE OF THE RECEIVABLE WILL BE REASSIGNED TO AN ACTIVE SERVICE OFFICE.

(12) LEVIES (AMOUNT WE PAID FOR YOU)

CHECK-NO	HOLDER-NO	NAME OF LEVEY HOLDER	AMOUNT
400012908	000000123	LEVY HOLDER	-100.00
		* TOTAL LEVIES	-100.00

Sample

(13) CLAIMS SPECIFIC		(14) NON CLAIMS SPECIFIC			(15)
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
155.00	.00	.00	100.00	.00	55.00

How to Read the Paid Claim with Levy Deduction EOB

1.-11. This information, printed on each page of the EOB, is explained on a preceding page entitled “How to Read the EOB.”

12. **LEVIES (AMOUNTS MEDI-CAL DENTAL PAID FOR THE PROVIDER)**: When an EOB reflects a levy deduction, the levy amount is shown with the following information:

    Check Number - The number of the check issued to the levy holder by Medi-Cal Dental.

    Holder Number - The number issued by Medi-Cal Dental to the levy holder upon receipt of a levy request.

    Name of Levy Holder - The name of the levy holder, e.g., the Internal Revenue Service.

    Amount - The amount of the payment issued to the levy holder by Medi-Cal Dental, shown as a negative amount. The levy amount shown in the sample is deducted from the check issued to the provider referenced on this EOB.

13. **CLAIMS SPECIFIC**: Lists the totals for all adjudicated claim lines listed on the sample.
14. **NON CLAIMS SPECIFIC**: This area on the sample shows the levy amount ($100.00) deducted from the amount of the check issued to the provider which corresponds to this EOB.
15. **CHECK AMOUNT**: The amount shown for this check ($55.00) reflects the Claims Specific Amounts paid listed in Field 13 ($155.00) minus the Non-Claims Specific Levy Amount Shown in Field 14 ($100.00).

Sample Levy Payment

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER
No **XXXXXXXXXX**

CHECK
No **XXXXXXXX**

TAX ID NO:
xxxxxxxxx-

DATE: **mm/dd/yy** **PAGE NO.** **x**
OF **x**

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B	BENEFICIARY NAME	MEDI-CAL I.D. NO.	BENE ID	SEX	BIRTH DATE

C	DOCUMENT CONTROL NO.	TOOTH CODE	PROC. CODE	DATE OF SERVICE	STA-TUS	REASON CODE	AMOUNT BILLED	ALLOWED AMOUNT	SHARE OF COST	OTHER COVERAGE	AMOUNT PAID

THE ENCLOSED CHECK IS IN PAYMENT ON THE FOLLOWING LEVY HELD BY YOU:

1 LEVY NBR	2 ACCOUNT OF	3 NPI/TAX-ID	4 CHECK NO.
000000083	JAMES ADAMS	XXXXXXXXXX	010300764

5 AMOUNT OF PAYMENT

50.00

Sample

6

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
					55.00

How to Read the Levy Payment EOB

This is an example of an EOB that would accompany a levy payment to a levy holder, e.g., the Internal Revenue Service, made by Medi-Cal Dental on behalf of the provider.

1. **LEVY NBR**: The number issued by Medi-Cal Dental that identifies the levy.
2. **ACCOUNT OF**: The name of the provider for whom the levy payment is being made.
3. **NPI/TAX ID**: The National Provider Identifier or Tax Identification Number of the provider for whom the levy payment is being made.
4. **CHECK NO**.: The number of the check, issued to the provider, from which the levy payment is deducted. The provider's EOB will identify the number of the check issued to the levy holder, the levy number, the name of the levy holder, and the amount of the levy payment issued.
5. **AMOUNT OF PAYMENT**: Shows the amount of the payment to the levy holder.
6. **CHECK AMOUNT**: The amount of the check sent by Medi-Cal Dental to the levy holder.

Sample Documents In-Process

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER
No xxxxxxxxxx

CHECK
No xxxxxxxx

Adams, James, DDS
30 Center Street
Anytown, CA xxxxx-xxxx

DATE: mm/dd/yy PAGE NO. x of x

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B BENEFICIARY NAME | MEDI-CAL I.D. NO. | BEND ID | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STA-TUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

(1) **DOCUMENTS IN-PROCESS**

(2) LAST NAME	(3) FIRST NAME	(4) MEDI-CAL ID	(5) BENE - ID	(6) DOB	(7) DCN	(8) AMT BILLED	(9) *CODE	
LAST	FIRST	XXXXX999D	99999999D	mm/dd/yy	08168108450	567.00	C	IR
LAST	FIRST	99999999D	99999999D	mm/dd/yy	08169103850	423.00	T	CS
LAST	FIRST	XXXXX999D	99999999D	mm/dd/yy	08175100684	112.00	C	IR

(10) TOTAL DOCUMENTS IN-PROCESS 3 (11) TOTAL BILLED 1102.00

(12) * THE FOLLOWING LEGEND HAS BEEN INCLUDED FOR IN-PROCESS STATUS CODES

C = CLAIM N = NOA T = TAR R = TAR REEVALUATION

DV - DATA VALIDATION (DOCUMENT IS AWAITING REVIEW OF KEYED DATA AGAINST DOCUMENT INFORMATION)
IR - INFORMATION REQUIRED (AN RTD FOR ADDITIONAL INFORMATION OR AN EDI REQUEST FOR XRAYS/ATTACHMENTS WAS SENT TO PROVIDER)
RV - RECIPIENT VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF RECIPIENT INFO)
PV - PROVIDER VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF PROVIDER INFO)
PR - PROFESSIONAL REVIEW (DOCUMENT IS SCHEDULED FOR PROFESSIONAL REVIEW)
CS - CLINICAL SCREENING (DOCUMENT IS SCHEDULED FOR CLINICAL SCREENING REVIEW)
SR - STATE REVIEW (DOCUMENT IS SCHEDULED FOR REVIEW BY STATE STAFF)

++

(13) THE NEXT SCHEDULED BASIC SEMINAR WILL BE HELD IN ANYTOWN ON 09/10/08 FROM 9:00 AM TO 12:00 PM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS

++

(14) THE NEXT SCHEDULED ADVANCED SEMINAR WILL BE HELD IN ANYTOWN ON 09/11/08 FROM 8:00 AM TO 12:00 PM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS

++

THE NEXT SCHEDULED WORKSHOP SEMINAR WILL BE HELD IN ANYTOWN ON 10/15/08 FROM 9:00 AM TO 4:00 PM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS

++

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT

Sample

How to Read the Documents In-Process EOB

The “Documents In-Process” section printed on the EOB will list information on all in-process documents grouped together by type of document (C = Claim, N = NOA, T = TAR, and R = TAR Reevaluation) and in-process status (professional review, state review, information required, etc).

1-8 **DOCUMENTS-IN-PROCESS**: Information listed in these areas of the sample is a description of each document that has been “in process” for 18 days or longer.

9. **CODE**: The appropriate code listed indicates the reason that the claim is “in process.”
10. **TOTAL CLAIMS IN PROCESS**: The example shows the total number of documents “in process.”
11. **TOTAL BILLED**: Total billed amounts for the documents “in process.”
12. The last page of the EOB containing in-process documents information provides a legend listing the reason codes for documents in process. Beside each code is a printed explanation which defines the reason a particular document is “in process.”
13. Medi-Cal Dental notifies the provider of upcoming provider training seminars with a message appearing at the end of the Explanation of Benefits (EOB) statement.
14. The location of the training seminar(s) nearest the provider’s office is determined automatically and will be printed on the EOB.

Sample Accounts Receivable

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER
No **XXXXXXXXXX**

NOT ISSUED REF
TAX ID NO:
XXXXXXXXX-

CHECK
No **XXXXXXXX**

DATE: **mm/dd/yy** **PAGE NO.** **x**
OF **x**

Adams, James, DDS
30 Center Street
Anytown, CA xxxxx-xxxx

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B BENEFICIARY NAME | MEDI-CAL I.D. NO. | BENE ID | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STA-TUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

** IF THERE IS A LACK OF RECENT DENTI-CAL ACTIVITY FOR THIS SERVICE OFFICE, THE OUTSTANDING
** BALANCE OF THE RECEIVABLE WILL BE REASSIGNED TO AN ACTIVE SERVICE OFFICE.

RECEIVABLES (AMOUNT YOU OWE US):
******* THE FOLLOWING IS ACCOUNT ACTIVITY NOT RELATED TO SPECIFIC CLAIMS:

(2) EFFECTIVE DATE	(3) PRINCIPAL BALANCE	(4) INTEREST APPLIED	(5) PD,VOID,OR TRANSFERRED	(6) CURRENT BALANCE	(7) TRANSACTION TYPE
(1) A/R NBR: 01907	(8) REMARKS: INTERNAL ADJUSTMENT				
08/01/08	600.00	0.00	0.00	0.00	
	600.00	0.00	0.00	0.00	

Sample

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC (9)			(10)
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
.00	.00	.00	.00	.00	600.00

How to Read the Accounts Receivable (AR) EOB

1. **A/R NBR**: The number assigned by Delta Dental that identifies the accounts receivable (the amount the provider owes Delta).
2. **EFFECTIVE DATE**: The date the accounts receivable was created.
3. **PRINCIPAL BALANCE**: The amount of the accounts receivable when it was created.
4. **INTEREST APPLIED**: If applicable, is the amount of interest applied to the outstanding A/R. Always factored in, it is now recorded
5. **PD, VOID, OR TRANSFERRED**: The amount the provider has paid or that has been deducted from the provider's check towards the accounts receivable.
6. **CURRENT BALANCE**: The current amount the provider owes on the accounts receivable.
7. **TRANSACTION TYPE**: If applicable, this reflects the type of payment transaction(s).
8. **REMARKS**: This area provides an explanation for the accounts receivable. In this example, Delta issued an overpayment to the provider for a document with DCN 98104100330.
9. **NON CLAIMS SPECIFIC A/R AMOUNT**: The total of the accounts receivable listed on the EOB or the amounts owed by the provider.
10. **CHECK AMOUNT**: The final amount of the check issued to the provider that corresponds to this EOB.

Sample Accounts Payable

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER No XXXXXXXXXX

TAX ID NO: XXXXXXXXX-

CHECK No XXXXXXXX

DATE: mm/dd/yy PAGE NO. x OF x

Adams, James, DDS
30 Center Street
Anytown, CA xxxxx-xxxx

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B BENEFICIARY NAME | MEDI-CAL I.D. NO. | BENE ID | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STA-TUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

** IF THERE IS A LACK OF RECENT DENTI-CAL ACTIVITY FOR THIS SERVICE OFFICE, THE OUTSTANDING
** BALANCE OF THE RECEIVABLE WILL BE REASSIGNED TO AN ACTIVE SERVICE OFFICE.

RECEIVABLES (AMOUNT YOU OWE US):

******* THE FOLLOWING IS ACCOUNT ACTIVITY NOT RELATED TO SPECIFIC CLAIMS.

PAYABLES/CASH RECEIPTS (AMOUNTS OWED TO YOU/PAID BY YOU)

1 PAYABLE NUMBER	2 REASON CODE	3 DESCRIPTION	5 AMOUNT
0000435	5	PAYABLE	50.00
0000436	5	4 CHECK # 123456 APPLIED TO ACCOUNT	50.00

6 TOTAL OF CHECK NUMBER 000123456 100.00

Sample

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC (7)			(8)
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
.00	.00	100.00	.00	.00	100.00

How to Read the Accounts Payable (AP) EOB

1. **PAYABLE NUMBER**: The number assigned by Delta Dental that identifies the accounts payable (the amounts Delta owes the provider).
2. **REASON CODE**: The code that identifies the reason for the payable. See “Section 7: Codes” of this Handbook for the AR/AP Reason Codes and Descriptions.
3. **DESCRIPTION**: An explanation of the transaction.
4. **CHECK #**: The number of the check that the provider sent to Delta.
5. **AMOUNT**: Lists the dollar amount of each payable listed on the EOB.
6. **TOTAL OF CHECK NUMBER**: The amount of the check the provider sent to Delta.
7. **NON CLAIMS SPECIFIC PAYABLES AMOUNT**: The total amount of the provider accounts payable shown on this EOB.
8. **CHECK AMOUNT**: The final amount of the check issued to the provider that corresponds to this EOB.

Sample Readjudicated Claim

EXPLANATION OF BENEFITS

DENTI-CAL
CALIFORNIAMEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY

PROVIDER No xxxxxxxxxx

CHECK No xxxxxxxx

DATE: mm/dd/yy PAGE NO. x of x

Adams, James, DDS
30 Center Street
Anytown, CA 95814

STATUS CODE DEFINITION
P = PAID
D = DENIED
A= ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

B BENEFICIARY NAME | MEDI-CAL I.D. NO. | BENE ID | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC. CODE | DATE OF SERVICE | STA-TUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

ADJUSTMENT CLAIMS

B	LAST	FIRST					99999999D	99999999D		F	mm/dd/yy
C #30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED											
C 08168101357	15	D7210	06/10/08	A	266B		- 95.00	- .00			- .00
C	14	D2140	06/10/08	A		(1)	- 50.00	- 39.00	(2)		(3) - 39.00
C	13	D2140	06/10/08	A			- 50.00	- 39.00			- 39.00
CLAIM TOTAL							-195.00	-78.00			-78.00

B	LAST	FIRST					99999999D	99999999D		F	mm/dd/yy
(4) C #30: NEW OR ADDITIONAL DOCUMENTATION SUBMITTED											
C 08168101357	15	D7210	06/10/08	P		(5)	95.00	85.00	(6)		(7) 85.00
C	14	D2140	06/10/08	P			50.00	39.00			39.00
C	13	D2140	06/10/08	P			50.00	39.00			39.00
CLAIM TOTAL							195.00	163.00			163.00
(8) *TOTAL ADJUSTED CLAIMS							.00	85.00			85.00
**PROVIDER CLAIMS TOTAL							132.00	186.00			186.00

Sample

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
101.00	85.00	.00	.00	.00	186.00

How to Read the Readjudicated Claim EOB

The original claim is described in the top section of the “ADJUSTMENT CLAIMS” section of the sample. The description of the results of the readjudication of the previously processed claim is found in the lower portion of the “ADJUSTMENT CLAIMS” section. The areas on the sample EOB that distinguishes the original claim information from the readjudicated claim information is as follows:

Original Claim Information

1. The status code “A” indicates this claim service line on the original claim was allowed.
2. The amount that was allowed for this claim service line when the claim service line was originally processed.
3. The amount of the payment that was made to the provider for this claim service line when the claim was originally processed by Medi-Cal Dental.

Readjudicated Claim Information

1. The code and description indicate why the claim was readjudicated. Descriptions of Readjudication Codes and Messages
   (Claim Correction Codes) can be found in “Section 7: Codes” of this Handbook.
2. The status code “P” indicates the claim service line was “paid” after readjudication.
3. This amount ($85.00) shows the amount allowed for this claim service line after readjudication.
4. The amount listed is the total amount paid to the provider for the readjudicated claim service line.
5. Total adjusted claims: This line shows the amounts allowed and to be paid to the provider after the claim was readjudicated.