



**Texas CHIP Dental Services**

P.O. Box 537014  
 Sacramento, CA 95853-7014  
 866-561-5891

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

1. Patient Name (Last, First, M.I.)		2. Patient Social Security Number		3. Sex M ; F		4. Patient Birthdate Month   Day   Year		5. Patient I.D. Number					
6. Patient Address							7. Patient Dental Record Number						
City, State					ZIP Code		8. Referring Provider Number						
9. Radiographs Attached? Check if YES		11. Accident/Injury? Check if YES		13. Other Dental Coverage? Check if YES		15. Delta Dental Group Number							
How Many? _____		YES		YES		14. Name and Address of Other Carrier(s)							
10. Other Attachments/Documentation? YES		12. Employment Related?				16. MF-0 Maxillofacial – Orthodontic Services?		YES					
17. Billing Provider Name (Last, First, M.I.)			18. Provider I.D. Number		19. Business NPI Number		22. X-Ray I.D. # (For Internal Use)						
20. Mailing Address				Telephone Number ( )									
City, State				ZIP Code									
21. Place of Service		Hospital In-Patient		Hospital Out-Patient		Other (Please Specify)							
Office	Home	Clinic	SNF	ICF									
23. Identify Missing Teeth with "X"					24. Examination and treatment – List in order from tooth no. 1 through no. 32.								
IDENTIFY MISSING TEETH WITH "X"  					25. Tooth no. or Letter arch	26. Surface	27. Description of service (including x-rays, prophylaxis, materials used, etc.)	28. Date service completed	29. Qty.	30. Procedure Number	31. Total Fee Charged	32. Treating Provider Number	
							1						
							2						
							3						
							4						
							5						
							6						
							7						
							8						
							9						
							10						
							11						
							12						
							13						
							14						
		15											
33. Comments									34. Total Fee Charged				
									35. Patient Co Pay Amount				
									36. Other Coverage Amount				
38. 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.									37. Date Billed				

X \_\_\_\_\_  
 SIGNATURE DATE TREATING NPI NUMBER

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

**IMPORTANT NOTES**

1. PLACE X-RAYS IN AN ENVELOPE AND ATTACH TO THIS FORM.
2. STAPLE ALL OTHER ATTACHMENTS TO THIS FORM.

## **IMPORTANT**

### AUTHORIZATIONS AND PAYMENTS

The services listed on this form have been personally provided to the patient by the provider or, under his or her direction, by another person authorized under the Delta Dental Participating Provider Agreement to provide such services, and such person(s) are designated on this form. The services were, to the best of the provider's knowledge, necessary to the health of the patient. The provider understands that payment for services rendered will be made from Federal and/or State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and/or State laws. The provider agrees to keep for a minimum of (5) five years from the date of service all records which are necessary to disclose fully the extent of services furnished to the patient. The provider agrees to furnish these records and any other information regarding payments claimed for providing the services, on request, to Delta Dental State Government Programs, the Texas Health and Human Services Commission; the Texas Department of Insurance; The Texas State Auditor's office; the U.S. Department of Health and Human Services, or their duly authorized representatives.

The provider agrees to accept those fees set forth in the applicable program Participating Provider Agreement as payment in full for Covered Dental Services and not seek from an enrollee or the State of Texas any surcharge or other additional payment not provided for in the Enrollee's Program, regardless of whether or not payment is received from Delta Dental. Whenever Delta Dental receives notice of such surcharges it shall take appropriate action. Neither Enrollees nor the State of Texas shall be liable to provider for any sums owed by Delta Dental. This prohibition shall not apply to co-payments, third party collections, non-covered dental services or optional treatments.

Dental care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, physical or mental disability, marital status, or sexual orientation.