TRANSMITTAL FORM

☐ **TAR** ☐ **APPEAL** ☐ **CORRECTION**

INSTRUCTIONS:

Each group of TARs presented via Mail, Fax or Onsite to the Field Office, Pharmacy Section or Appeals Section may include this form. Providers who would like to receive a copy of the Transmittal Form as an acknowledgement of receipt of submitted TARs **must send 2 copies** of the completed Transmittal Form and a self-addressed stamped envelope.

DELIVERY METHOD: ☐ **MAIL** ☐ **FAX** ☐ **ONSITE**

FACILITY INFORMATION:

Name _____ National Provider Identifier (NPI) _____

Address _____

City and ZIP _____ Contact Person _____

Phone ( ) _____ Fax ( ) _____ Date Sent _____

Date Stamp

Initials _____

STATE USE ONLY

Patient's Name	Medi-Cal Identification Number	TAR Sequence Number	Admit Date	Discharge Date	# of Pages Sent for Review	# of Pages Received by Field Office
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

For **STATE** use only**:**

PAGE _____ OF _____ (including this form)

Date Returned to Facility: _____ Returned By: _____