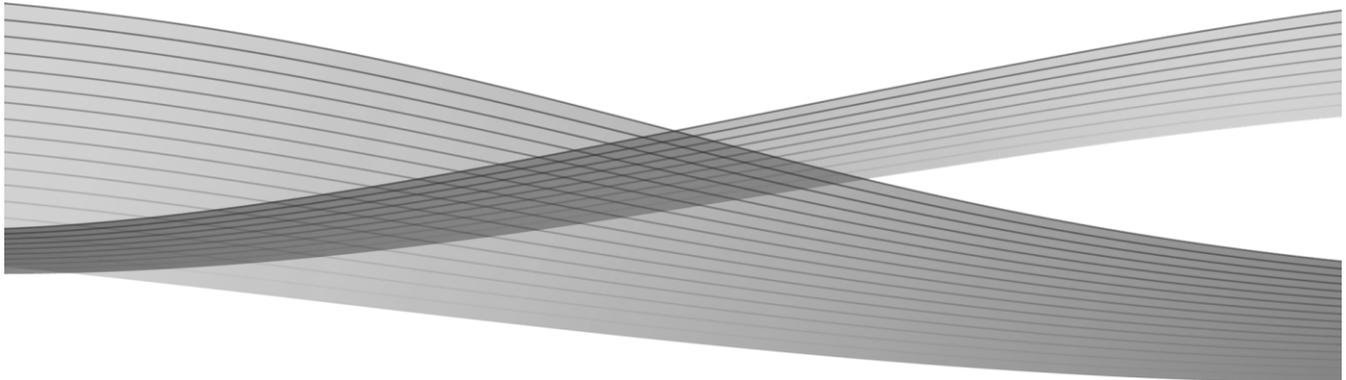




Treatment Authorization Request Medical User Guide 2016

Durable Medical Equipment





The Outreach and Education team includes Regional Representatives, the Small Provider Billing Unit (SPBU) and Coordinators who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment.

The Medi-Cal Learning Portal (MLP) brings Medi-Cal learning tools into the 21st Century. Simply complete a one-time registration to gain access to the MLP's easy-to-use resources. View online tutorials, live and recorded webinars from the convenience of your own office and register for provider training seminars. For more information call the Telephone Service Center (TSC) at 1-800-541-5555 or go to the MLP at <http://www.medi-cal.ca.gov/education.asp>.

Free Services for Providers

Provider Seminars and Webinars

Provider training seminars and webinars offer basic and advanced billing courses for all provider types. Seminars are held throughout California and provide billing assistance services at the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative.

Regional Representatives

The 24 Regional Representatives live and work in cities throughout California and are ready to visit providers at their office to assist with billing needs or provide training to office staff.

Small Provider Billing Unit

The four SPBU Specialists are dedicated to providing one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the SPBU Billing Assistance and Training Program, call 916-636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!

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Module A. Introduction

Section 1. Training Policy

This User Guide is a tool to be used for training and as a desktop reference.

The Medi-Cal provider manual contains the most current program, policy, and claims information. The provider manual is updated monthly and is accessible on the Medi-Cal website.

Section 2. eTAR Acronyms

ANSI	American National Standards Institute
BIC	Benefits Identification Card
CAASD	Clinical Assurance & Administrative Support Division
CCS	California Children's Services
CPSP	Comprehensive Prenatal Services Program
DHCS	Department of Health Care Services
DME	Durable Medical Equipment
DOS	Date of Service
DX	Diagnosis Code
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ETAR	Electronic Treatment Authorization Request
FPACT	Family Planning, Access, Care and Treatment
FQHC	Federally Qualified Health Center
ICF	Intermediate Care Facility
ICF-DD	Intermediate Care Facility Developmentally Disabled
ICF-DDH	Intermediate Care Facility Developmentally Disabled Habilitative
ID	Identification
IHO	In Home Operation
LTC	Long Term Care
MDS	Minimum Data Set
MMDDYYYY	Two digit month and date, four digit year (ex. 10232015)
NCPDP	National Council for Prescription Drug Program
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OHC	Other Health Care Coverage
OCR	Optical Character Recognition
PED	Provider Enrollment Department
PI	Pricing Indicator
PIN	Personal Identification Number
POC	Plan of Care
POE	Proof of Eligibility
POS	Point of Service
TSC	Telephone Service Center
SOC	Share of Cost
SSL	Secure Socket Layer
TAR	Treatment Authorization Request
TCN	TAR Control Number

Section 3. Purpose and Objectives

The purpose of this guide is to familiarize users with the Medi-Cal electronic Treatment Authorization Request (eTAR) website so that users may submit eTARs online.

Upon completion of this training, participants will be able to:

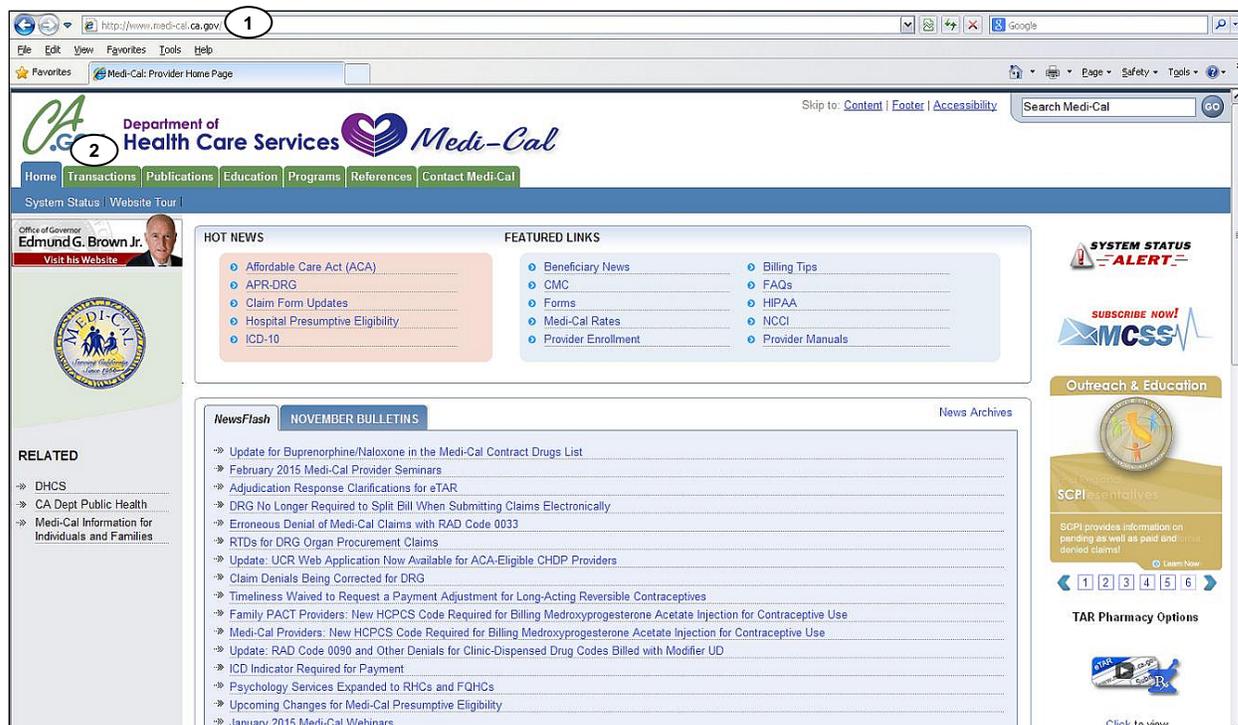
- ◆ Access the Medi-Cal website.
- ◆ Log in to the Transaction Services menu.
- ◆ Access the TAR menu.
- ◆ Create eTARs, update eTARs and check TAR statuses online.
- ◆ Submit attachments.

General Guidelines

- ◆ An asterisk symbol (*) means the field is required.
- ◆ A downward arrow next to a field means there is a drop-down list that will allow the user to choose from existing options.
- ◆ Decimal points are required when indicated.
- ◆ Verify the cursor is located in a field before using the backspace key to delete a character.
- ◆ Dates must be completed with a two digit month, two digit date and four digit year (mmddyymm). Example: June 10, 2015 is 06102015.
- ◆ Do not click back in the internet browser while submitting an eTAR.
- ◆ The eTAR Medical Tutorials link is accessible from the upper right corner on all eTAR Medical webpages.
- ◆ If a window does not appear and the fax attachments option is selected, a pop-up blocker may be active.
- ◆ Enter a rendering provider number to allow another provider to inquire on eTAR service information.

Module B. Accessing the TAR Menu

Section 1. Accessing the TAR Menu



- To access the Medi-Cal website, enter (*www.medi-cal.ca.gov*) in the address bar of the browser. To ensure that all customer data transmitted over the internet remains confidential, the Department of Health Care Services (DHCS) and the DHCS Fiscal Intermediary (FI) have instituted electronic security measures using industry-standard encryption technology, including:
 - Authentication: Requiring users to enter ID and password
 - Secure Socket Layer (SSL) technology: Online two-way data encryption
- Click **Transactions** tab from the Medi-Cal home page.
Website Help: Call the Telephone Support Center at 1-800-541-5555.

Accessing the TAR Menu

CA.GOV Department of Health Care Services Medi-Cal

Home Transactions Publications Education Programs References Contact Medi-Cal

System Status | Login | Services Available | Enrollment Requirements

Home

Login to Medi-Cal

WARNING: This is a State of California computer system that is for official use by authorized users and is subject to being monitored and/or restricted at any time. Confidential information may not be accessed or used without authorization. Unauthorized or improper use of this system may result in administrative disciplinary action and/or civil and criminal penalties. By continuing to use this system you indicate your awareness of and consent to these terms and conditions of use. **LOG OFF IMMEDIATELY** if you are not an authorized user or do not agree to the conditions stated in this warning.

All ASC X12N 837 v.4010A1 transactions submitted on or after 5 p.m. on April 30, 2013, will be deleted with CMC error codes 58: Media type/claim type not valid for this submitter and 55: Submitter/claim type not approved for included attachment.

Any 4010/4010A1 or NCPDP 5.1/1.1 transactions submitted after this date will be rejected and result in non payment of claims.

Submitters who have not certified or converted to ASC X12N 5010 and NCPDP D.0/1.2 formats can contact the Computer Media Claims (CMC) Help Desk to schedule testing by calling the Telephone Service Center (TSC) at 1-800-541-5555 and selecting option 4 then option 2.

Additional information can be located on the HIPAA/5010/4010/NCPDP page located under the References tab of the Medi-Cal website.

Please enter your User ID and Password. Click Submit when done.

Visit Transaction Enrollment Requirements for Medi-Cal.

Please enter your User ID: **3**

Please enter your Password: **4**

5

Note: The eTAR application requires logging in using an NPI number.
All eTARs will be denied if logging in using a legacy number.
Exemption: Legacy number usage is permitted only to Providers authorized by the Department of Health Care Services (DHCS).

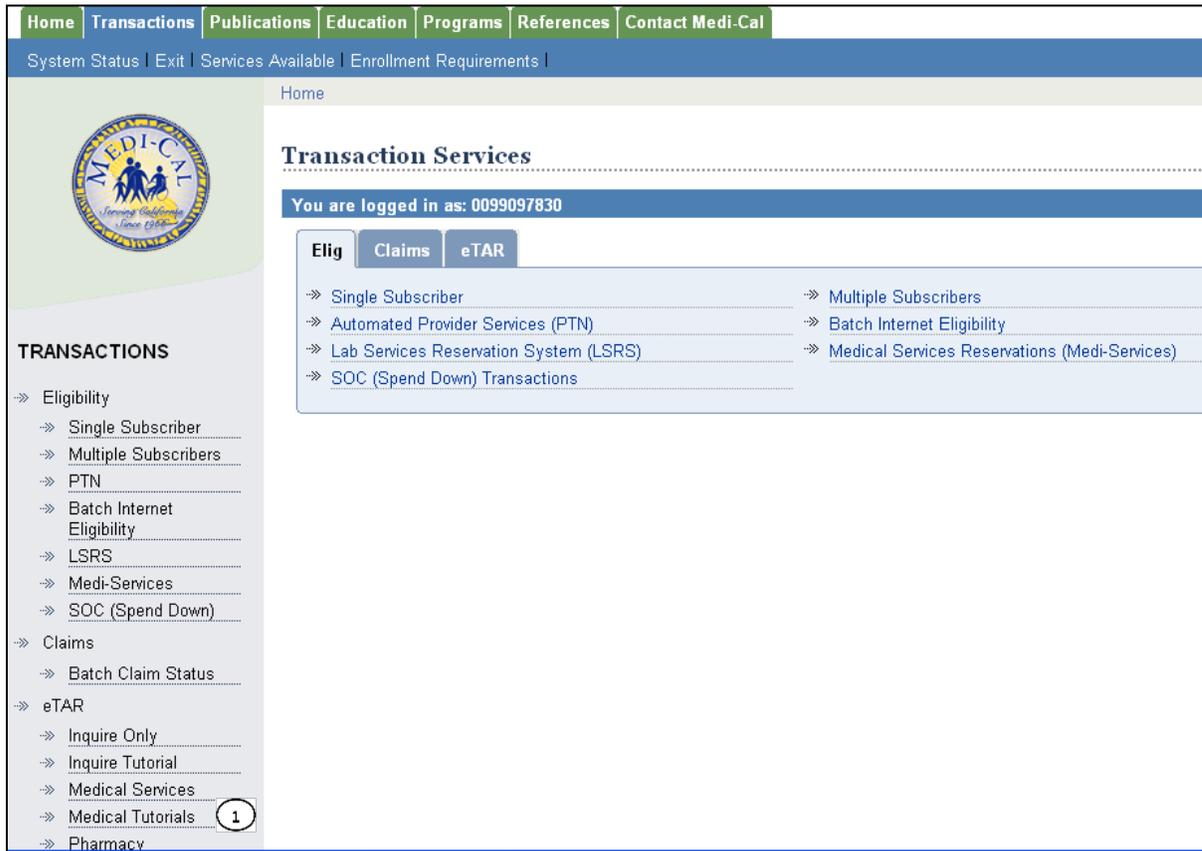
Be careful to protect your user ID and password to prevent unauthorized use.

Contact Medi-Cal | Medi-Cal Site Help | Medi-Cal Site Map

3. Enter the 10 digit National Provider Identifier (NPI) in the **Please enter your User ID** field. Legacy number usage is permitted only to providers authorized by the Department of Health Care Services (DHCS).
4. Enter the seven digit Medi-Cal Personal Identification Number (PIN) in the **Please enter your Password** field.
5. Click **Submit** to authenticate the User ID and Password.

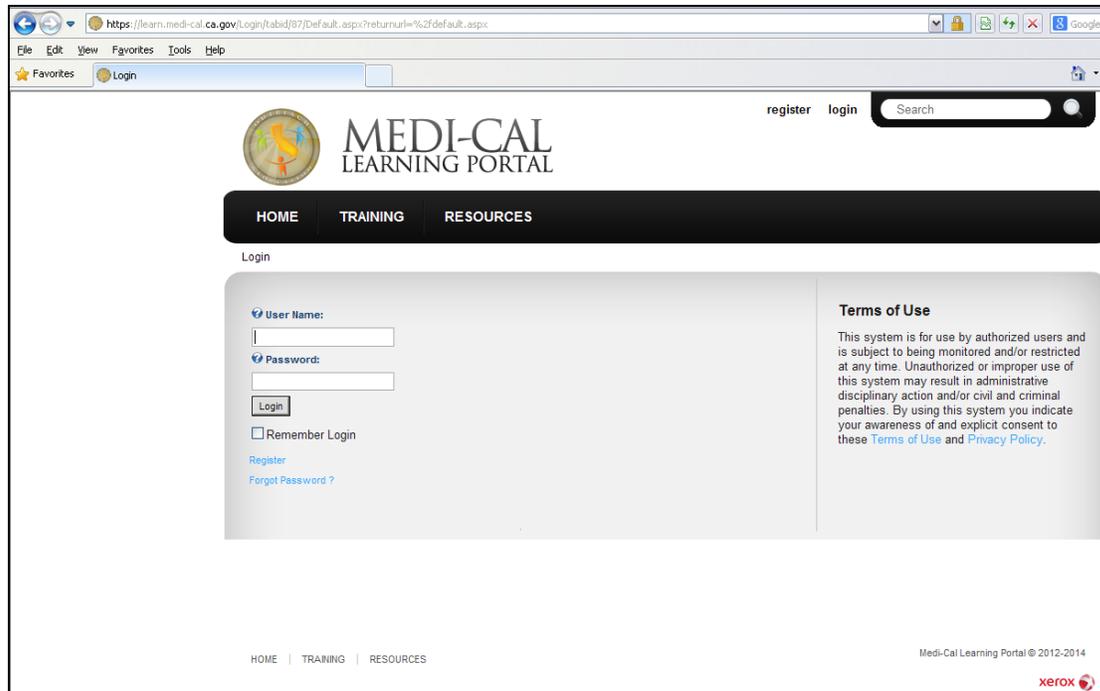
NOTE: If unable to log in, call the Telephone Support Center at 1-800-541-5555.

Section 2. eTAR Medical Tutorials



1. In the left-side column under **Transactions** and under **eTAR**, click **Medical Tutorials** for a step-by-step explanation of how to submit medical eTARs. A window opens and connects you to the Medi-Cal Learning Portal.

Accessing the TAR Menu

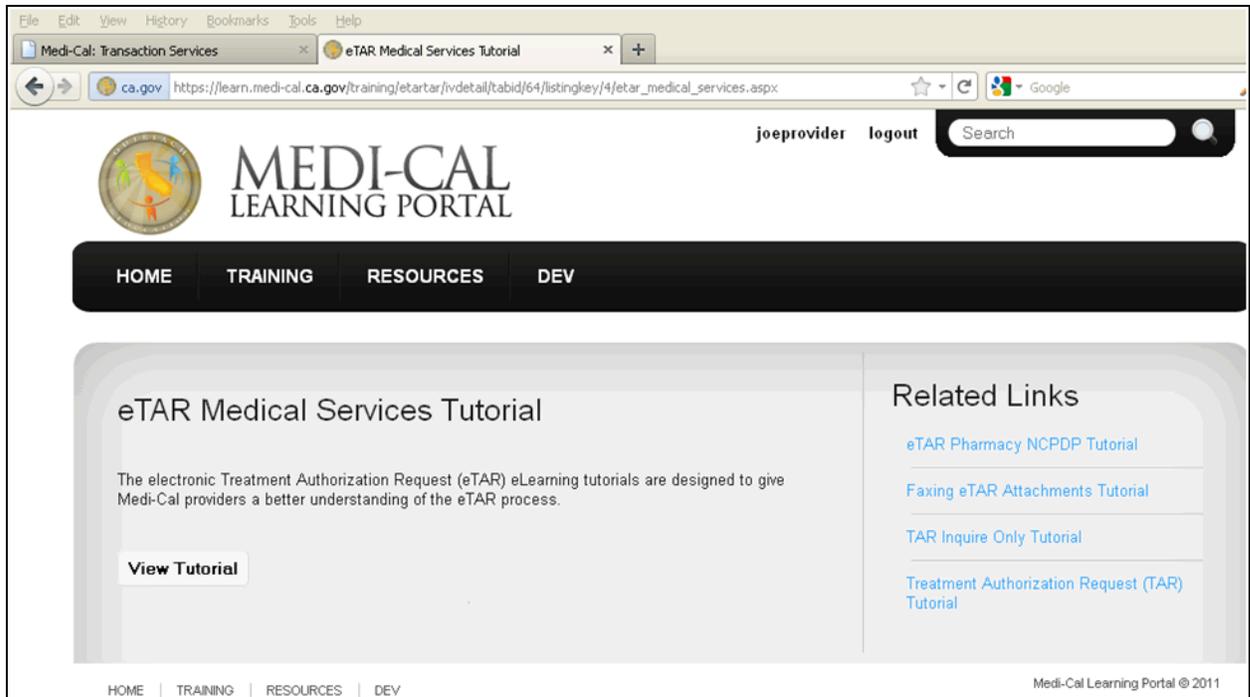


The screenshot shows the Medi-Cal Learning Portal login page. At the top, there is a navigation bar with "register" and "login" links, and a search box. Below this is a dark navigation bar with "HOME", "TRAINING", and "RESOURCES" links. The main content area is titled "Login" and contains a login form with fields for "User Name:" and "Password:", a "Login" button, and a "Remember Login" checkbox. There are also links for "Register" and "Forgot Password?". To the right of the login form is a "Terms of Use" section with a disclaimer. At the bottom of the page, there is a footer with "HOME | TRAINING | RESOURCES" and "Medi-Cal Learning Portal © 2012-2014" along with a Xerox logo.

Enter the **User Name** and **Password** that you registered with the Learning Portal.

NOTE: You must be registered to be able to log in and access the Tutorials. If you are not registered, you may do so now. To register:

- ◆ Click either the **register** link located at the top right of the screen or the **Register** link below the **Remember Login** option.
- ◆ Follow the prompts and complete the fields to register.



Click **View Tutorial**. A new window opens.

Accessing the TAR Menu

Click **Start the Tutorial**.

Click the play button > at the bottom of the Introduction screens to learn how to navigate the Presentation and Interactive tutorial.

Click >| to advance to the next slide.

Click |< to go back to the previous slide.

NOTE: There is currently no audio in the tutorials.

After the Introduction, an overview tutorial begins explaining the process for submitting medical eTARs, using easy-to-follow steps.

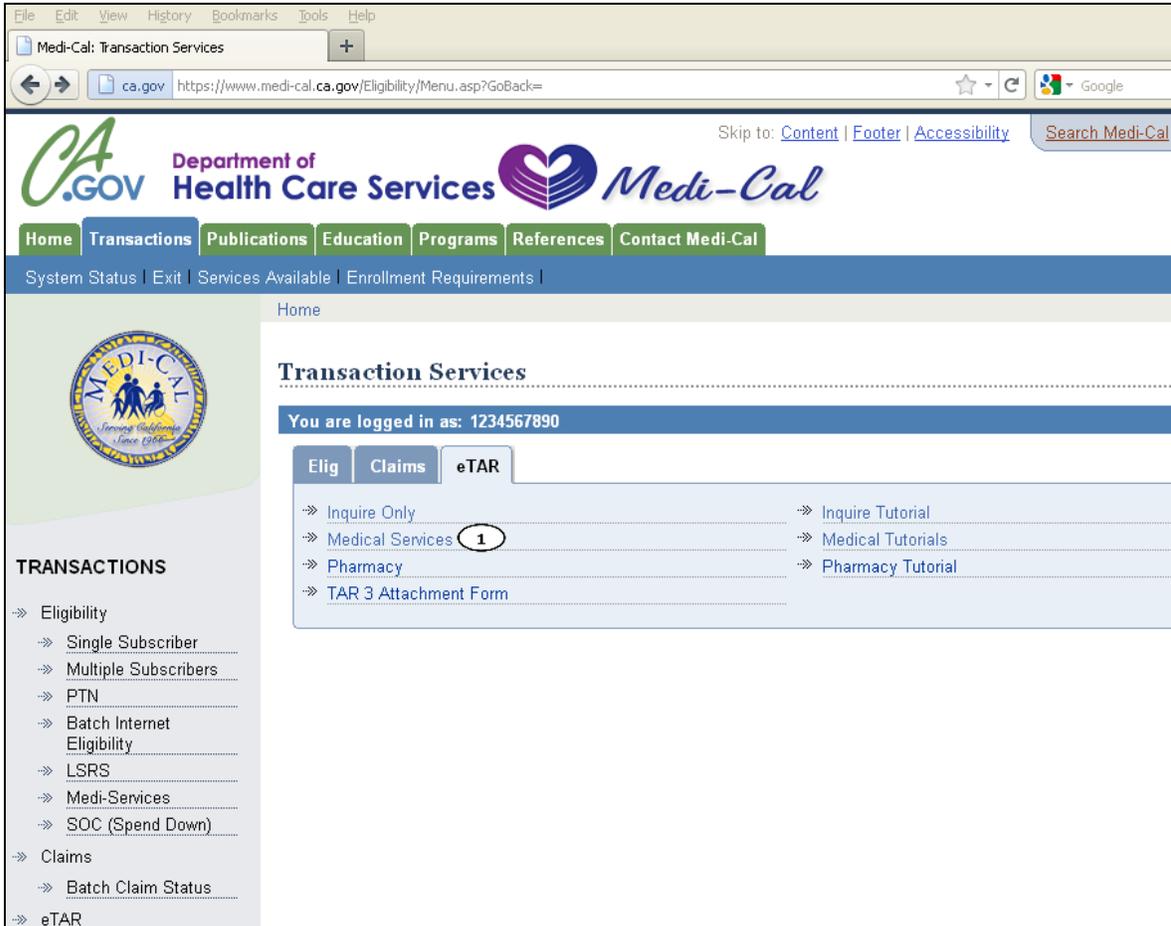
When done with the tutorial, close the session by clicking **X** in the window of this session.

To log out of the Medi-Cal Learning Portal, click **Log Out** at the top right half of the window.

Remember to also log out of your Medi-Cal session. Click on **Exit** on the blue bar below the **Transactions** tab located at the upper half of the screen to end the login session completely.

Module C. Create a New eTAR

Section 1. Treatment Authorization Request Menu



1. Click **Medical Services** from the Transaction Services menu to go to the TAR Menu.

Create a New eTAR

The screenshot shows a web browser window displaying the Medi-Cal Treatment Authorization Request (TAR) menu. The browser's address bar shows the URL: <https://www.medi-cal.ca.gov/cgi-forte/forteisapi.dll?ServiceName=surgewebservice&templateName=TARMain.htm&UserID>. The page header includes the CA.GOV logo, Department of Health Care Services, and Medi-Cal logo. A search bar is located in the upper right corner. The main navigation menu includes: Home, Transactions, Publications, Education, Programs, References, and Contact Medi-Cal. The breadcrumb trail shows: Home -> Transaction Services. The page title is "TAR Menu". Below the title, there is a link for "eTAR Medical Tutorials". A welcome message reads: "Welcome to the Treatment Authorization Request (TAR) menu. Please choose from one of the following options:". The options are listed as follows:

- 2 -> Create a New TAR
- > Update an existing TAR
- > Upload TAR Attachments
- > Inquire on a TAR
- > View TAR Responses
- > Code Search

On the left side, there is a sidebar menu with the following items:

- TAR
 - > New TAR
 - > Update TAR
 - > Attachments
 - > TAR Inquiry
 - > TAR Response
 - > Code Search
 - > Pharmacy Service
- TRANSACTIONS

2. Click **Create a New TAR** to submit an eTAR.

NOTE: The eTAR Medical Tutorials are accessible from the upper right corner on all eTAR Medical webpages.

Section 2. Provider Address Selection Option

Treatment Authorization Request

eTAR Medical Tutorials

The legal name(s) for Provider ID 1234567890 is(are):

SEAN'S MEDICAL SERVICE

Provider Address Selection Options:

Address Line	End Date	Provider Type(s)	Telephone
1 123 MY PLACE DR, HOMETOWN, CA 90000-1000	12/31/2069	PHYSICIANS	(555)555-5555
1445 NPI DR, ANYTOWN, CA 95823-1000	12/31/2069	ORTHOTISTS	(916)555-4567

NOTE: Please click on the appropriate address location.

If a National Provider Identifier (NPI) has multiple addresses associated with it, select the address where services will be rendered.

1. Click the provider **Address** to indicate the provider type for the eTAR being submitted.

NOTE: Do not click Back from the Internet browser while submitting an eTAR.

Section 3. User Information

TAR

- » New TAR
- » TAR Menu
- » Code Search
- » Pharmacy Service

TRANSACTIONS

- » [Transaction Services](#)
- » [Exit](#)

Please Enter Provider Information

1 Submitting Provider #
1234567890

3 Provider Name
COMMUNITY MEDICAL CLINIC

Phone #
(916) 636-1200

Street/Mailing Address
820 Stillwater Road

City
W. Sacramento

2 Medicare Cert?

4 Fax #
() -

State Zip Code
CA 95670

5 Contact Name

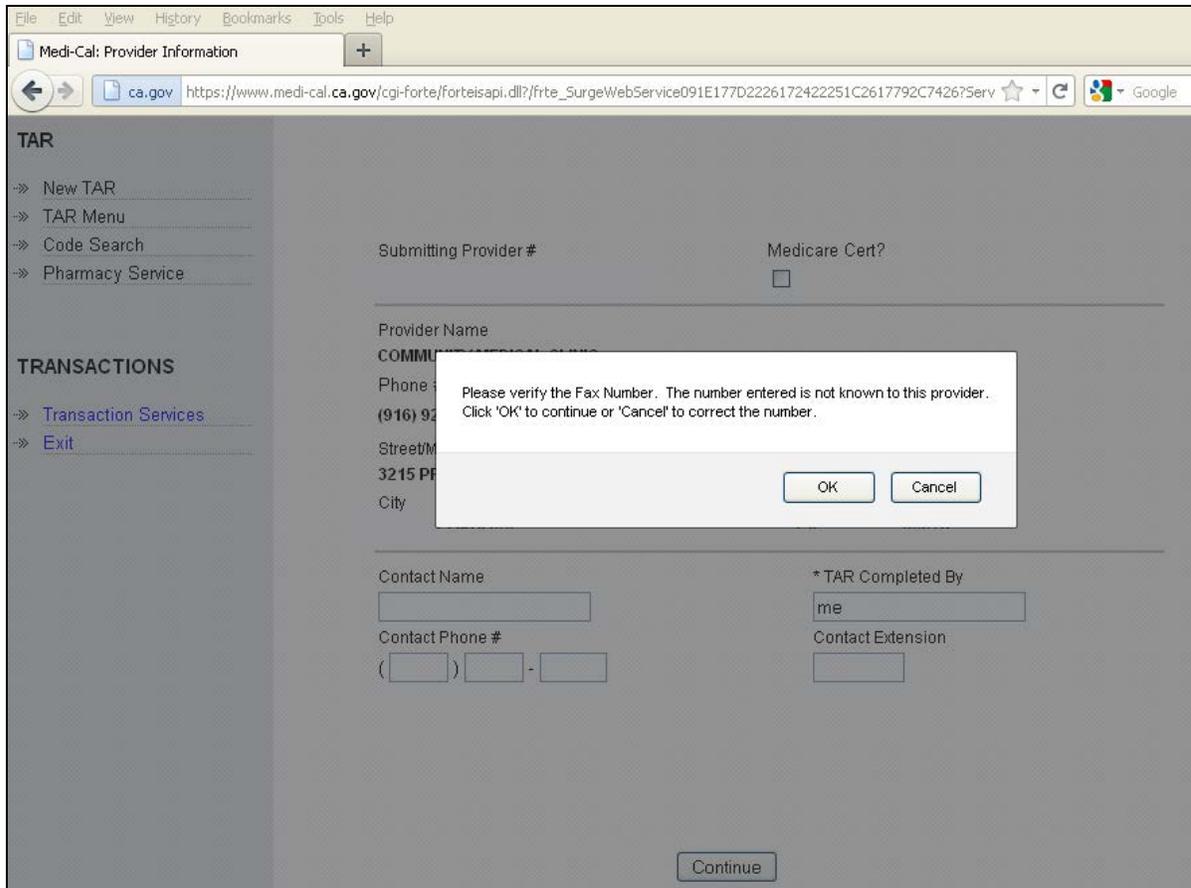
7 Contact Phone #
() -

6 *TAR Completed By

8 Contact Extension

9

1. The **Submitting Provider #** used to log in to Transaction Services will automatically populate. If an eTAR needs to be submitted under a different provider number, log out and log in using the correct provider number.
2. Click the **Medicare Cert?** checkbox to indicate the user is Medicare certified.
3. Under **Provider Name**, the submitting provider's name, phone and address will automatically populate.
4. For vision providers only, if a **Fax #** is entered, an Adjudication Response (AR) will be automatically faxed with eTAR details. If the field is left blank, an AR will not be sent and eTAR status may be viewed and printed through Inquire on a TAR.
5. Enter the **Contact Name** of the person who has the ability to answer questions about the eTAR request.
6. Enter the full name of the person who completed the eTAR in **the TAR Completed By** field. *Always required.
7. Enter the **Contact Phone #** for the person who can answer questions about the eTAR.
8. Enter the **Contact Extension** of the contact person.
9. Click **Continue** to proceed to the Patient Information page.



If the fax number entered is not recognized by Medi-Cal databases, a window will appear requesting verification of the fax number. Click **OK** if the fax number is correct.

Click **Cancel** to change the fax number.

Section 4. Patient Information

The screenshot shows a web form titled "Please Enter Patient Information". On the left is a sidebar with the heading "TAR" and four menu items: "New TAR", "TAR Menu", "Code Search", and "Pharmacy Service". The main form area contains three numbered fields: 1. "* Recipient ID #" (a text input field with an asterisk indicating it is required), 2. "Patient Record #" (a text input field), and 3. "Special Handling" (a drop-down menu). The form is enclosed in a rectangular border.

1. Enter the **Recipient ID #** printed on the State of California Benefits Identification Card (BIC). * Always required.
2. The **Patient Record #** is an optional field to help a user inquire on a specific eTAR or recipient. The number is created by the submitting user. Examples may include patient medical record number or patient account number.
3. Use the **Special Handling** drop-down list to select a special handling code for the eTAR service being requested. This field is only required if one of the listed reasons apply. See the Medi-Cal Provider Manual for further information.
 - *6 Prescription Limit* – Select when the recipient has exceeded their 6 prescription limit.
 - *ADHC Regional Centers* – Select when Community-Based Adult Services (CBAS) applies.
 - *Beneficiary Exempt from Hearing Aid Cap* – Select when the maximum hearing aid cap has been met and the beneficiary meets the criteria of those who are excluded from the cap.
 - *Breast and Cervical Cancer Treatment Program (BCCTP)* – Select when the Breast and Cervical Cancer Treatment Program (BCCTP) applies.
 - *CCT – California Community Transitions* – Select when the California Community Transitions (CCT) program applies.
 - *CHDTP*– Select when the specialized Child Health Disability and Treatment Program (CHDTP) Treatment program for children applies.
 - *Cannot Bill Direct, TAR is Required* – Select when the service cannot be claimed direct and a TAR is required in order to submit a claim.
 - *Charpentier*– Select when processing the special rules of Medicare or Medi-Cal Charpentier program.
 - *Concurrent Review - Fax* –Currently not in use.
 - *Concurrent Review - Onsite* – Currently not in use.
 - *Container Count Limit* – Select when the request exceeds the maximum number of containers as specified in the Medi-Cal Provider Manual for a compound drug.

- *DPO* – Select when facilitating an early discharge from the hospital for a Discharge Planning Option (DPO).
- *EPSDT Supplemental Services* – Select when a request is beyond normal Early Periodic Screening Diagnosis and Treatment (EPSDT) program scope.
- *Elective Acute Day Hospitalization* – Select when requesting for elective hospital days.
- *Emergency Acute Day Hospitalization* – Select when requesting for inpatient hospital days or administrative days.
- *Exceeded Billing Dollar Amount* – Select when the maximum dollar amount allowed for the service within a specific timeframe has been exceeded
- *Exceeded Billing Frequency Limit* – Select when the number of times this service may be provided within a specific timeframe has been exceeded, therefore, prior authorization is required.
- *Exceeded Billing Limit* – Select when the quantity billable for this service has been exceeded, therefore, prior authorization is required.
- *Exceeded Code 1 Restrictions* – Select when the recipient has exceeded the Code 1 restricted limits for a drug, as specified in the Medi-Cal Provider Manual.
- *Exceeded Inhalers Supply Limit* – Select when the eTAR service request exceeds the inhaler assist device limits, as specified in the Medi-Cal Provider Manual.
- *Exceeded Medical Supplies Limit/ Container Count Limit* – Select when the recipient has exceeded their medical supply or container count limit, as specified in the Medi-Cal Provider Manual.
- *Exceeded Peak Flow Meters Limit* – Select when the recipient has exceeded their peak flow meter supply limit, as specified in the Medi-Cal Provider Manual.
- *FPACT* – Select for complications with Family Planning, which may be covered by Family Planning Access Care and Treatment (FPACT) but only with a TAR.
- *FPACT 6 Prescription Limit* – Currently not in use, 6 Rx limit does not apply to Family PACT.
- *Hudman* – Select when requesting authorization to a nursing facility in a distinct part of an acute facility in lieu of placement at a free- standing nursing facility.
- *ICF-DD Clinical Assurance Review* – Select for authorization to an Intermediate Care Facility for the Developmentally Disabled (ICF-DD).
- *IHO* – Select for an evaluation, possible authorization and case management with the In-Home Operations (IHO) program.
- *MCM – Obsolete after April 30, 2011* – Currently not in use.
- *Out-of-State Acute Day Hospitalization* – Select when requesting acute day hospitalization outside the state of California.

Create a New eTAR

- *Podiatry* – Select for a Podiatry service.
- *Services is a non-benefit and no TAR requirement on procedure file – REVIEW-* Select when the service being claimed is a non-benefit and does not require a TAR but is needed by the patient and must be prior authorized.
- *Service/Product Exempt from Hearing Aid Cap* – Select when hearing aid service/product is excluded from the hearing aid cap.
- *Step Therapy Exemption* – Select when the TAR meets exemption from step therapy requirements.
- *Transfer* – Select when moving a patient from one nursing facility to another.
- *Usage is for Non-Standard Diagnosis* – Select when non-standard diagnosis applies.
- *Valdivia* – Select for services in excess of those provided normally to a nursing facility patient.

NOTE: If the service typically does not require a TAR but still needs to be evaluated by a field office reviewer, select Can Not Bill Direct, TAR is Required.

The screenshot shows a form with the following fields and their corresponding numbers in circles:

- 4 * Patient's Last Name (text input)
- 5 * Patient's First Name (text input)
- 6 Phone # (text input with parentheses and dashes)
- 7 * Date of Birth (text input)
- 8 * Male Female (radio buttons)
- 9 * Work Related? (radio buttons: No, Yes, Unknown)
- 10 Residence Status (dropdown menu, currently showing 'None')
- 11 * Medicare Denial Reason (dropdown menu, currently showing 'Under 65, does not have Medicare Coverage')
- 12 Medicare/OHC Denial Date (text input)
- 13 * OHC Denial Reason (dropdown menu, currently showing 'No Other Health Coverage')

4. Enter the **Patient's Last Name**. *Always required.
5. Enter the **Patient's First Name**. *Always required.
6. Enter the **Phone #** of the patient.
7. Enter the patient's **Date of Birth** (mmddyyyy). *Always required.
8. Click the circular **Male** or **Female** radio button to indicate the patient's gender. *Always required
9. Click the circular **Work Related?** radio button if the claim is work related. *Always required.
10. Use the **Residence Status** drop-down list to select the residence status currently applicable for the patient.

- 11. Use the **Medicare Denial Reason** drop-down list to select the reason Medicare would not cover the requested services. *Always required.
- 12. Enter a **Medicare/OHC Denial Date** (mmddyyyy) if Medicare or Other Health Care Coverage has denied this service. If Medicare Denial Reason is entered, this field is required.
- 13. Use the **OHC Denial Reason** drop-down list to select the patient’s Other Healthcare Coverage status type. *Always required.

Mother/Transplant Recipient Providing Medi-Cal Eligibility

<p>14 Last Name <input style="width: 100%;" type="text"/></p> <p>16 Date of Birth <input style="width: 100%;" type="text"/></p>	<p>15 First Name <input style="width: 100%;" type="text"/></p> <p>17 Male <input type="radio"/> Female <input type="radio"/></p>
---	--

The mother or Transplant Recipient Providing Medi-Cal Eligibility section is used for submitting an eTAR for a newborn using the mother’s Medi-Cal eligibility or when an organ transplant donor is using the transplant recipient’s Meid-Cal eligibility.

- 14. Enter the **Last Name** of the infant’s mother or the transplant recipient providing Medi-Cal eligibility.
- 15. Enter the **First Name** of the infant’s mother or the transplant recipient providing Medi-Cal eligibility.
- 16. Enter the **Date of Birth** (mmddyyyy) for the infant’s mother or the transplant recipient providing Medi-Cal eligibility.
- 17. Click the circular **Male** or **Female** radio button to indicate the patient’s gender.

Create a New eTAR

The screenshot shows a form titled "Patient's Authorized Representative". It contains the following fields and a button:

- 18** Name: A text input field.
- 19** Street/Mailing Address: A text input field.
- 20** City: A text input field.
- 21** State: A dropdown menu.
- 22** Zip Code: A text input field.
- 23** Continue: A button.

Use the Patient's Authorized Representative section if the eTAR is for a Medi-Cal recipient who is under guardianship. All fields need to be completed in this section to ensure the Patient's Authorized Representative will receive all relevant correspondence concerning the patient.

18. Enter the **Name** of the patient's authorized representative.
19. Enter the **Street/Mailing Address** of the patient's authorized representative.
20. Enter **City** of residence for the patient's authorized representative.
21. Enter **State** of residence for the patient's authorized representative.
22. Enter the **Zip Code** of residence for the patient's authorized representative.
23. Click **Continue** to proceed to the TAR Services menu.

Module D. TAR Services – DME

Section 1. Service Category Selection

Add Service - Category Unknown

* **Service Code Search**

1 2

[eTAR Medical Tutorials](#)

Please Select a Service Category

When finished with all services, click [Submit TAR](#)

DME Services	LTC Services	Inpatient Services	Outpatient Services	Other Services
<ul style="list-style-type: none"> • Apnea Monitor • Beds • Hearing Aid • Incontinence Supplies • IV Equipment • Medical Supplies • Mobility • Orthotics/ Prosthetics • Ox/Respiratory • Pumps (non-IV) • Other 	<ul style="list-style-type: none"> • ICF-DD • NFA/NFB Non-Electronic MDS • Short Stay • Subacute 	<ul style="list-style-type: none"> • Hospital Days • Hyperbaric Oxygen • Radiology • Surgical/Other Procedures • Transplant Procedure-Kidney • Transplant Procedure-Other 	<ul style="list-style-type: none"> • Allergy • Cochlear Implants • CPSP • Dialysis • FPACT • HopTel • Hyperbaric Oxygen • Radiology • Office Visits - Restricted • Office Visits - Restricted Provider • Plasma Pheresis • Portable X-ray • Psychiatry • Surgical/Other Procedures • TeleMed • Transplant Acquisition 	<ul style="list-style-type: none"> • AAC • ADHC • Detox • EPSDT Nutritional • Home Health • Hospice • Non-Pharmacy Issued Drug • Respiratory Therapy • Speech/ Occupational /Physical Therapy • Transportation • Vision - Contact Lens / Evaluation • Vision - Low Vision Aids • Vision - Other Eye Appliances

1. Enter the service code in the **Service Code Search** field to identify the service being requested. If the service code is unknown, see Module J for additional information on Code Search.
2. Click **Find Service Category(s)** to initiate the search.

Service Category Selection

eTAR Medical Tutorials

Select appropriate service category for service code listed below:

Code	Description	Code Type	Service Category	Service Grp Desc	TAR Indicator
E1399	MISCELLANEOUS	P	DME - Other	SMA/HCPCS	TAR Required
E1399	MISCELLANEOUS	P	DME - Mobility	SMA/HCPCS	TAR Required
E1399	MISCELLANEOUS	P	3 DME - Beds	SMA/HCPCS	TAR Required
E1399	MISCELLANEOUS	P	Apnea Monitor	SMA/HCPCS	TAR Required
E1399	MISCELLANEOUS	P	Oxygen & Respiratory Equipment	SMA/HCPCS	TAR Required
E1399	MISCELLANEOUS	P	Pumps (non-IV)	SMA/HCPCS	TAR Required

*Code Type: P = Procedure L = Level of Care A = Accommodation

[Return to TAR Services Menu](#)

- Click the **Service Category** that applies to the services being submitted.

Section 2. Apnea Monitor

DME

eTAR Medical Tutorials

Please Enter Apnea Information

Attachment A

Service Information

* Service Code(HCPCS Code) Modifiers (if applicable)

1 2

Service Description (40 characters accepted)

3

* Total Units Ant. Length of Need

4 5 /

From Date Thru Date * Start of Care Discharge Date

1. Enter the **Service Code** identifying the service being requested. If the code was entered in Service Code Search, it will automatically populate. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search. *Always required.
2. Enter up to four **Modifiers**. If unknown, click the Modifier link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave the field blank.
4. Enter the **Total Units** requested. If requesting a rental, enter the number of rental months or days, depending on the service code entered. *Always required.
5. Enter the **Ant. Length of Need** to indicate the appropriate period of the requested services. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the patient will need the services for three months, enter:

Ant. Length of Need

3 / Month

NOTE: The eTAR Medical Tutorials link is accessible from the upper right corner on all eTAR Medical webpages.

TAR Services – DME

6	From Date mmddyyyy	7	Thru Date mmddyyyy	8	* Start of Care mmddyyyy	9	Discharge Date mmddyyyy
10	Discharge ▼						
11	Price	12	Pricing Override Request ▼	13	MSRP		
14	Place of Service ▼						
15	Rendering Provider # _____						

6. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive.
7. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.
8. Enter the **Start of Care** (mmddyyyy) date the patient began, or will begin, receiving the service requested. *Always required.
9. Enter the **Discharge Date** (mmddyyyy). If Discharge has been selected, this field is required.
10. Use the **Discharge** drop-down list to select the level of care for the patient.
11. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
12. Use the **Pricing Override Request** drop-down list to select an override code for unlisted items or prices.
13. Enter the **MSRP** (Manufacturer's Suggested Retail Price) or actual invoice price for the service being requested, up to seven digits.
14. Use the **Place of Service** drop-down list to select the location where the service is being rendered.
15. Enter a **Rendering Provider #** if rendering provider is different from the submitting provider. This will allow another provider to inquire on eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.

The screenshot shows a form with the following fields and labels:

- *ICD-CM Type** (Required): A drop-down menu labeled 16.
- *ICD Code (Decimal)** (Required): A text input field labeled 17.
- Diagnosis Description**: A text input field.
- Date of Onset**: A text input field labeled 18 with the format `mmddyyyy`.
- Enter Miscellaneous TAR Information (500 characters accepted)**: A large text area labeled 19.

16. Use the **ICD-CM Type** drop-down list to select the ICD code type.
17. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
18. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
19. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.
NOTE: For retroactive eTARs, make sure the requested **From Date** and **Thru Date** are entered.

Service <input type="button" value="Continue"/>			
Patient assessment information for this Service (Attachment A)			
Please list current medical status codes relevant to requested service(s)			
20	<input type="text"/>	<input type="text"/>	<input type="text"/>
21	ICD-CM Type	22	Date Of Onset
<input type="text"/>	<input type="text"/>	Diagnosis Description	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

20. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to requested service(s)** field. If unknown, click the medical status code link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes.

21. Use the **ICD-CM Type** drop-down list to select the ICD code type.

22. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.

NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.

23. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.

Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) -- include dates if applicable. (255 characters accepted)

22

If it is known that the patient has ever received the requested or similar service(s), please explain -- include dates. (255 characters accepted)

23

- 24. Enter a summary of the treatment and history of the patient in the **Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable** field.
- 25. Enter information regarding any similar services in the **If it is known that the patient has ever received the requested or similar service(s), please explain – include dates** field.

Prescribing Physician Information

* Physician Prescription (255 characters accepted)

26

* Physician's License #

27

* Physician's Name

28

* Physician's Phone

29

* Prescription Date

30

Attachment A Service

31 32

26. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. This replaces the need for submitting this information as an attachment. *Always required.
27. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. This replaces the need for submitting this information as an attachment. *Always required.
28. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
29. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
30. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.
31. Click **Continue** to return to the TAR Service menu. See Module E for information on submitting the eTAR.
32. Click **Another Service, Same Category** to create another service line for the same service type.

Section 3. DME Beds

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search. *Always required.
2. Enter up to four **Modifiers**. If unknown, click the Modifier link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave the field blank.
4. Use the **Side** drop-down list to select Right, Left or Bilateral.
5. Enter the **Total Units** requested. If requesting a rental, enter the number of rental months or days, depending on the service code entered. *Always required.
6. Enter the **Ant. Length of Need** to indicate the appropriate period of the requested services. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the patient will need the services for two months, enter:

NOTE: The eTAR Medical Tutorials link is accessible from the upper right corner on all eTAR Medical webpages

7	* From Date mmddyyyy	8	Thru Date mmddyyyy	9	* Start of Care mmddyyyy	10	Discharge Date mmddyyyy
11	Admit From [dropdown]						
12	Discharge [dropdown]						
13	* Place Of Service [dropdown]						
14	Rendering Provider # [text]						

7. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive
8. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.
9. Enter the **Start of Care** (mmddyyyy) date the patient began, or will begin, receiving the service requested. *Always required.
10. Enter the **Discharge Date** (mmddyyyy). If Discharge has been selected, this field is required.
11. Use the **Admit From** drop-down list to select the level of care from where the patient was admitted.
12. Use the **Discharge** drop-down list to select the level of care for the patient.
13. Use the **Place of Service** drop-down list to select the location where the service is being rendered. *Always required.
14. Enter a **Rendering Provider #** if rendering provider is different from the submitting provider. This will allow another provider to inquire on eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.

The screenshot shows a web form titled "Pricing Override Request". It contains several input fields and a text area, each with a circled number indicating its function:

- 15**: Pricing Override Request (drop-down menu)
- 16**: Price (text input)
- 17**: MSRP (text input)
- 18**: * ICD-CM Type (drop-down menu)
- 19**: * ICD Code (Decimal Required) (text input)
- Diagnosis Description (text input)
- 20**: Date of Onset (mmddyyyy) (text input)
- 21**: Enter Miscellaneous TAR Information (500 characters accepted) (large text area)

15. Use the **Pricing Override Request** drop-down list to select an override code for unlisted items or prices.
16. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
17. Enter the **MSRP** (Manufacturer’s Suggested Retail Price) or actual invoice price for the service being requested, up to seven digits.
18. Use the **ICD-CM Type** drop-down list to select the ICD code type.
19. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
20. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
21. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Attachment B Service

Patient assessment information for this Service (Attachment A)

P.O.T. Adherence

Feeding Method

In-Home Assistance/Care Giver Hrs/Day Days/Wk

Height ' "

Weight lbs. oz.

22. Use the **P.O.T Adherence** drop-down list to select the level of compliance the patient has to the Plan of Treatment.
23. Use the **Feeding Method** drop-down list to select the method of feeding for the patient.
24. Enter the amount of hours per day and days per week assistance is available to the patient in his or her home in the **In-Home Assistance/Care Giver** field.
25. Enter the patient's **Height** in feet and inches.
26. Enter the patient's **Weight** in pounds and ounces.

Please list current functional limitation /physical condition codes							
27	<input type="text"/>						
Please list previous functional limitation /physical condition codes							
28	<input type="text"/>						
Please list current medical status codes relevant to requested service(s)							
29	<input type="text"/>						

- 27. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes.
- 28. Enter the previous functional limitation or physical condition relative to the requested services. If unknown, click the functional limitation link to access Code Search. See Module in the **Please list previous functional limitation/physical condition codes** field J for more information on Code Search. See Appendix B for a list of functional limitation codes.
- 29. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes

ICD Code (Decimal ICD-CM Type Required)		Diagnosis Description	Date Of Onset
30	31		32
Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) -- include dates if applicable. (255 characters accepted)			
33			
If it is known that the patient has ever received the requested or similar service(s), please explain -- include dates (255 characters accepted)			
34			
Please summarize the therapeutic goal to be met with the requested service(s). (255 characters accepted)			
35			

30. Use the **ICD-CM Type** drop-down list to select the ICD code type.
31. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank
32. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
33. Enter a summary of the treatment and history of the patient in the **Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable** field.
34. Enter information regarding any similar services in the **If it is known that the patient has ever received the requested or similar service(s), please explain – include dates** field.
35. Enter a summary of the therapeutic goal to be met in the **Please summarize the therapeutic goal to be met with the requested service(s)** field.

Please list alternatives tried or considered and the reason why they are not feasible for this patient

Service Code	Describe Alternative Tried/Considered (30 characters accepted)
36 <input type="text"/>	37 <input type="text"/>
<input type="text"/>	Reason <input type="text"/> 38 <input type="text"/>
<input type="text"/>	Reason <input type="text"/>
<input type="text"/>	Reason <input type="text"/>
	Reason <input type="text"/>

Please explain why the least costly method of treatment is not being used. (255 characters accepted)

39

- 36. Enter the **Service Code** identifying a service that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
- 37. Enter details in the **Describe Alternative Tried/Considered** field. If an alternative service code has been entered in the adjacent field, leave the field blank.
- 38. Use the **Reason** drop-down list to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
- 39. Enter a brief explanation in the **Please explain why the least costly method of treatment is not being used** field.

Prescribing Physician Information

* Physician Prescription (255 characters accepted)

40

* Physician's License #

41

* Physician's Name

42

* Physician's Phone

43

* Prescription Date

44

40. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. This replaces the need for submitting this information as an attachment. *Always required.
41. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. This replaces the need for submitting this information as an attachment. *Always required.
42. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
43. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
44. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.

The screenshot shows a web form titled "Attachment A Service" with a "Continue" button. Below the title is the section "DME Attachment Form (Attachment B)".

Under "Unlisted Reason", there are three drop-down menus, each with a downward arrow. A circled number 45 is next to the first menu.

To the right, under "Ideal Weight", there is a text input field. A circled number 46 is next to the field.

At the bottom, there are three radio button questions:

- "Home Accessible?" with a circled number 47. The "No" radio button is selected.
- "Safe Operation?" with a circled number 48. The "No" radio button is selected.
- "Independent Operation?" with a circled number 49. The "No" radio button is selected.

45. If the service requested is for an unlisted code, use the **Unlisted Reason** drop-down lists to select up to three reasons why a listed code cannot be used in place of the unlisted code.

46. Enter the patient's **Ideal Weight** in pounds.

47. Click the circular **Home Accessible?** radio button to indicate if the patient's home is accessible for the Equipment.

48. Click the circular **Safe Operation?** radio button to indicate if the patient is able to operate the equipment requested safely.

49. Click the circular **Independent Operation?** radio button to indicate if the patient is able to operate the equipment requested independently.

Equipment Already in Home		* Turning Information		
Item	Usage (Hrs/Day)	* Turning Schedule Every "__" Hours		
50	51	52		
		* UTS	* RSN	
		53	54	
* Lab Date	Hemoglobin	Hematocrit	Albumin	
mmddyyyy	55	56	57	58

50. Use the **Item** drop-down lists to select the equipment already present in the home relevant to the requested service.
51. Enter the average number of hours per day the patient uses the equipment in the **Usage** field.
52. Enter the number of hours scheduled between each turning in the **Turning Schedule Every “_” Hours** field. This replaces the need for submitting this information as an attachment. *Always required.
53. Use the **UTS** drop-down lists to select Unavailable Turning Surface (UTS). This replaces the need for submitting this information as an attachment. *Always required.
54. For the UTS indicated, use the **RSN** drop-down lists to select the reason why the turning surface is unavailable for the patient. This replaces the need for submitting this information as an attachment. *Always required.
55. Enter the **Lab Date** (mmddyyyy) the Hemoglobin, Hematocrit and Albumin tests were taken. This replaces the need for submitting this information as an attachment. *Always required.
56. Enter the **Hemoglobin** lab score from the test taken on the Lab Date. Exclude the decimal point.
57. Enter the **Hematocrit** lab score from the test taken on the Lab Date. Exclude the decimal point.
58. Enter the **Albumin** lab score from the test taken on the Lab Date. Exclude the decimal point.

* Lab Date mmddyyyy	Hemoglobin <input type="text"/>	Hematocrit <input type="text"/>	Albumin <input type="text"/>
Serial # 59 <input type="text"/>	Manufacturer 60 <input type="text"/>	Model 61 <input type="text"/>	
Purchase Date 62 mmddyyyy	Purchased By 63 <input type="text" value="v"/>	Warr. Exp. Date 64 mmddyyyy	
Attachment A Attachment B Service			
65 <input type="button" value="Continue"/>		66 <input type="button" value="Another Service, Same Category"/>	

59. Enter the **Serial #** of the product.
60. Enter the **Manufacturer** of the equipment.
61. Enter the **Model** or stock number identifying the equipment.
62. Enter the original **Purchase Date** (mmddyyyy) for repair or replacements. Otherwise, leave the field blank.
63. If Purchase Date is entered, use the **Purchased By** drop-down list to select the original purchaser of the equipment.
64. Enter the expiration date for the warranty on the equipment in the **Warr. Exp. Date** (mmddyyyy) field. If later than the request date, an explanation or medical justification of why the warranty does not cover repair or replacement must be entered in Miscellaneous TAR Information.
65. Click **Continue** to return to the TAR Services menu. See Module E for information on submitting the eTAR.
66. Click **Another Service, Same Category** to create another service line for the same service type.

Section 4. Hearing Aid

DME

eTAR Medical Tutorials

Please Enter Hearing Aid Information

[Attachment A](#) [Attachment C](#)

Service Information

* **Service Code** (HCPCS Code) **Modifiers** (if applicable)

① ②

Service Description (40 characters accepted)

③

* **Side** **Total Units** **Rendering Provider #**

④ ⑤ ⑥

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search. *Always required.
2. Enter up to four **Modifiers**. If unknown, click the Modifier link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave the field blank.
4. Use the **Side** drop-down list to select Right, Left or Bilateral. *Always required.
5. Enter the **Total Units** requested. If a trial period is being requested, enter the number of rental days for the trial.
6. Enter a **Rendering Provider #** if the rendering provider is different from the submitting provider. This will allow another provider to inquire on eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.

NOTE: The eTAR Medical Tutorials link is accessible from the upper right corner on all eTAR Medical webpages.

The screenshot shows a form with the following fields and labels:

- From Date** (7) mmddyyyy
- Thru Date** (8) mmddyyyy
- Pricing Override Request** (9) [Drop-down menu]
- Price** (10) [Text input]
- * ICD-CM Type Required** (11) [Drop-down menu]
- * ICD Code (Decimal)** (12) [Text input]
- Diagnosis Description** [Text input]
- Date of Onset** (13) mmddyyyy
- Enter Miscellaneous TAR Information (500 characters accepted)** (14) [Text area]

7. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive.
8. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.
9. Use the **Pricing Override Request** drop-down list to select an override code for unlisted items or prices.
10. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
11. Use the **ICD-CM Type** drop-down list to select the ICD code type.
12. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
13. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
14. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Attachment C Service

Patient assessment information for this Service (Attachment A)

Please list current [functional limitation](#) /physical condition codes

15

Please list previous [functional limitation](#) /physical condition codes

16

Please list current [medical status](#) codes relevant to requested service(s)

17

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
18 <input type="text"/> ▼	19 <input type="text"/>	<input type="text"/>	20 <input type="text"/>
<input type="text"/> ▼	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> ▼	<input type="text"/>	<input type="text"/>	<input type="text"/>

15. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes.
16. Enter the previous functional limitation or physical condition relative to the requested services in the **Please list previous functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes.
17. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes.
18. Use the **ICD-CM Type** drop-down list to select the ICD code type.
19. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank
20. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.

Service Code	Describe Alternative Tried/Considered (30 characters accepted)
21	22
Reason	23
Reason	
Reason	
Reason	

Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) -- include dates if applicable. (255 characters accepted)

24

* If it is known that the patient has ever received the requested or similar service(s), please explain -- include dates. (255 characters accepted)

25

21. Enter the **Service Code** identifying a service that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
22. Enter details in the **Describe Alternative Tried/Considered** field. If an alternative service code has been entered in the adjacent field, leave the field blank.
23. Use the **Reason** drop-down list to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
24. Enter a summary of the treatment and history of the patient in the **Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable** field.
25. Enter information regarding any similar services in the **If it is known that the patient has ever received the requested or similar service(s), please explain – include dates** field. This replaces the need for submitting this information as an attachment.
*Always required.

The screenshot shows a form titled "Prescribing Physician Information". It contains five input fields, each with a circled number indicating a step:

- 26**: A large text area for the "Physician Prescription (255 characters accepted)".
- 27**: A text box for the "Physician's License #".
- 28**: A text box for the "Physician's Name".
- 29**: A text box for the "Physician's Phone" number, formatted as () - .
- 30**: A text box for the "Prescription Date".

26. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. This replaces the need for submitting this information as an attachment. *Always required.
27. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. This replaces the need for submitting this information as an attachment. *Always required.
28. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
29. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
30. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.

The screenshot shows a web form titled "Attachment A Service" with a "Continue" button. Below it is the "Audiologic Attachment Form (Attachment C)". The form contains four fields: 1. "* Examiner/Provider" with a text input field (circled 31). 2. "Altern. Test" with a checkbox (circled 32). 3. "* Exam Date" with a text input field (circled 33). 4. "* Exam Location" with a drop-down menu (circled 34).

- 31. Enter the Provider number of the **Examiner/Provider**. This replaces the need for submitting this information as an attachment. *Always required.
- 32. Click the **Altern. Test** checkbox to indicate if an alternate test was performed due to the patient not speaking English. If this field is selected, the alternate test method and results are required in the remarks field.
- 33. Enter the **Exam Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.
- 34. Use the **Exam Location** drop-down list to select the Place of Service (POS) in which the exam was performed. This replaces the need for submitting this information as an attachment. *Always required.

Pure Tone Audiometry			
Right Side: MHZ		Left Side: MHZ	
	500	1000	2000
35 Air	<input type="text"/>	<input type="text"/>	<input type="text"/>
36 Bone	<input type="text"/>	<input type="text"/>	<input type="text"/>
37 Air (Mask)	<input type="text"/>	<input type="text"/>	<input type="text"/>
38 Bone (Mask)	<input type="text"/>	<input type="text"/>	<input type="text"/>

At least one row of values must be completed for the Right Side and Left Side, unless included on a freeform attachment, if an alternate test method was used.

35. Enter the pure tone audiometry test score for **Air** mode exam recorded for the right and left ear at 500, 1000 and 2000 MHZ.
36. Enter the pure tone audiometry test score for **Bone** mode exam recorded for the right and left ear at 500, 1000 and 2000 MHZ.
37. Enter the pure tone audiometry test score for **Air (Mask)** mode exam recorded for the right and left ear at 500, 1000 and 2000 MHZ.
38. Enter the pure audiometry test score for **Bone (Mask)** mode exam recorded for the right and left ear at 500, 1000 and 2000 MHZ.

Speech Audiometry

Sound Field 39 * Ear Fitted 40 Language 41 Monitored

Test	Under Headphones		Unaided	Aided	Aided
	Right	Left		Present	New
SRT	42 db	db	db	db	db
WDS in quiet	43 %	%	%	%	%
MCL	44 db	db	UCL	45 db	db

Remarks (255 characters accepted)

46

39. Use the **Ear Fitted** drop-down list to select the ears fitted with aids. This replaces the need for submitting this information as an attachment. *Always required.
40. Use the **Language** drop-down list to select the language in which the test was administered.
41. Use the **Monitored** drop-down list to indicate if the test was monitored.
42. Enter the speech audiometry test score (measured in decibels) for Speech Reception Threshold (SRT) for Under Headphones- Right or Left, Unaided, Aided-Present (as indicated by Ear Fitted) and Aided-New (as indicated by Ear Fitted) in the **SRT** field.
43. Enter the speech audiometry test score (measured in percentage) for Word Discrimination Score (WDS) in Quiet for Right or Left ear Under Headphones, Unaided, Aided-Present (as indicated by Ear Fitted) and Aided-New (as indicated by Ear Fitted) in the **WDS in quiet** field.
44. Enter the speech audiometry test score (measured in decibels) for Most Comfortable Loudness (MCL) for Right or Left ear Under Headphones in the **MCL** field.
45. Enter the speech audiometry test score (measured in decibels) for Uncomfortable Loudness (UCL) for Aided-Present (as indicated by Ear Fitted), Aided-New (as indicated by Ear Fitted) in the **UCL** field.
46. Enter alternate testing method and results if testing was done in English but no scores were listed, or if testing was done in another language in the **Remarks** field. For repairs or replacements, the field may be used to explain why the existing warranty does not cover the request.

Hearing Aid Replacement/Repair Information		
Left Side		
Service Code 47 <input type="text"/>	Replace? 48 <input checked="" type="radio"/> No <input type="radio"/> Yes	Replace Rsn. 49 <input type="text"/>
	Repair? 50 <input checked="" type="radio"/> No <input type="radio"/> Yes	Repair Rsn. 51 <input type="text"/>
Serial # 52 <input type="text"/>	Model <input type="text"/>	
Manufacturer <input type="text"/>		
Purchase Date <input type="text"/>	Purchased By <input type="text"/>	Warranty Expiration Date <input type="text"/>

47. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
48. Click the circular **Replace?** radio button to indicate if the requested service is a replacement for a left side hearing aid. If “Yes” is selected, the replacement reason is required.
49. Use the **Replace Rsn.** drop-down list to select the reason for replacing the existing left side hearing aid with the requested product.
50. Click the circular **Repair?** radio button to indicate if the requested service is a repair for a left side hearing aid. If “Yes” is selected, the repair reason is required.
51. Use the **Repair Rsn.** drop-down list to select the reason for repairing the existing side hearing aid.
52. Enter the **Serial #** of the product.

Hearing Aid Replacement/Repair Information

Left Side

Service Code

Replace?
 No Yes

Repair?
 No Yes

Replace Rsn.

Repair Rsn.

Serial #

Model

Manufacturer

Purchase Date

Purchased By

Warranty Expiration Date

- 53. Enter the **Model** or stock number identifying the equipment.
- 54. Enter the **Manufacturer** of the equipment.
- 55. Enter the original **Purchase Date** (mmddyyyy).
- 56. Use the **Purchased By** drop-down list to select the original purchaser of the equipment.
- 57. Enter the **Warranty Expiration Date** (mmddyyyy) on the equipment. If later than the request date, an explanation or medical justification of why the warranty does not cover repair or replacement must be entered in Miscellaneous TAR Information.

Right Side
Service Code (58)

Replace? (59) No Yes

Repair? (61) No Yes

Replace Rsn. (60)

Repair Rsn. (62)

Serial # (63)

Model (64)

Manufacturer

Purchase Date

Purchased By

Warranty Expiration Date

[Attachment A](#) [Attachment C](#) [Service](#)

58. Enter the **Service Code** to identify the right side hearing aid which is being replaced or u. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
59. Click the circular **Replace?** radio button to indicate if the requested service is a replacement of a right side hearing aid. If “Yes” is selected, the replacement reason is required.
60. Use the **Replace Rsn.** drop-down list to select the reason for replacing the existing right side hearing aid with the requested product.
61. Click the circular **Repair?** radio button to indicate if the requested service is a repair of a right side hearing aid. If “Yes” is selected, the repair reason is required.
62. Use the **Repair Rsn.** drop-down list to select the reason for repairing the existing right side hearing aid.
63. Enter the product **Serial #**.
64. Enter the **Model** or stock number identifying the equipment.

Right Side

Service Code

Replace?
 No Yes

Replace Rsn.

Repair?
 No Yes

Repair Rsn.

Serial #

Model

Manufacturer
 65

Purchase Date
 66

Purchased By
 67

Warranty Expiration Date
 68

Attachment A Attachment C Service

69 **70**

65. Enter the **Manufacturer** of the equipment.
66. Enter the original **Purchase Date** (mmddyyyy).
67. Use the **Purchased By** drop-down list to select the original purchaser of the equipment.
68. Enter the **Warranty Expiration Date** (mmddyyyy) on the equipment. If later than the request date, an explanation or medical justification of why the warranty does not cover repair or replacement must be entered in Miscellaneous TAR Information.
69. Click **Continue** to return to the TAR Services menu. See Module E for information on submitting a eTAR.
70. Click **Another Service, Same Category** to create another service line for the same service type.

Section 5. Incontinence Supplies

DME

[eTAR Medical Tutorials](#)

Please Enter Incontinence Supply Information

Attachment A Attachment D

Service Information

* Service Code (HCPCS Code or Medical Supply Code) Modifiers (if applicable)

1 2

Service Description (40 characters accepted) * Total Units

3 4

* Quantity * Frequency Ant. Length of Need

5 / / /

1. Enter the **Service Code** to identify the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search. *Always required.
2. Enter up to four **Modifiers**. If unknown, click the Modifier link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave the field blank.
4. Enter the **Total Units** requested. *Always required.
5. Enter the **Quantity** for the number of units to be used per time period. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If 200 units are anticipated to be used per month, enter:

* Quantity

200 / Month

NOTE: The eTAR Medical Tutorials link is accessible from the upper right corner on all eTAR Medical webpages.

The screenshot shows a form with the following fields and their corresponding numbers in circles:

- 6**: *Frequency (input field and dropdown menu)
- 7**: Ant. Length of Need (input field and dropdown menu)
- 8**: From Date (input field with mask mmddyyyy)
- 9**: Thru Date (input field with mask mmddyyyy)
- 10**: Rendering Provider # (input field)

Other fields visible include: *Quantity, Pricing Override Request, *Place of Service, and Price.

6. Enter the **Frequency** for the number of units that will be used per time period. Enter the number of units in the first field and use the drop-down list to select the time period.
*Always required.

Example: If 10 units per day will be needed, enter:

* Frequency
10 / Day

7. Enter the **Ant. Length of Need** to indicate the appropriate period of the requested services. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the patient will need the services for the remainder of their life, use the drop-down list to select:

Ant. Length of Need
1 / Lifetime

8. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive.
9. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.
10. Enter a **Rendering Provider #** if rendering provider is different from the submitting provider. This will allow another provider to inquire on eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.

The screenshot shows a web form titled "Pricing Override Request". It contains several input fields and a text area, each with a circled number indicating its function:

- 11**: A drop-down menu labeled "Pricing Override Request".
- 12**: A text input field labeled "Price".
- 13**: A drop-down menu labeled "* Place of Service".
- 14**: A drop-down menu labeled "*ICD-CM Type".
- 15**: A text input field labeled "*ICD Code (Decimal Required)".
- 16**: A text input field labeled "Date of Onset" with a placeholder "mmddyyyy".
- 17**: A large text area labeled "Enter Miscellaneous TAR Information (500 characters accepted)".

11. Use the **Pricing Override Request** drop-down list to select an override code for unlisted items or prices.
12. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If **Pricing Override Request** is selected, this field is required.
13. Use **Place of Service** the drop-down list to select the location where the service is being rendered. *Always required.
14. Use the **ICD-CM Type** drop-down list to select the ICD code type.
15. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
16. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
17. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Attachment D Service Continue

Patient assessment information for this Service (Attachment A)

Height Weight

18 , " 19 lbs. oz.

Please list current [functional limitation](#) /physical condition codes

20

Please list previous [functional limitation](#) /physical condition codes

21

Please list current [medical status](#) codes relevant to requested service(s)

22

18. Enter the patient’s **Height** in feet and inches.
19. Enter the patient’s **Weight** in pounds and ounces.
20. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes.
21. Enter the previous functional limitation or physical condition relative to the requested services in the **Please list previous functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes.
22. Enter current medical status codes which describe the patient’s condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes.

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
23 <input type="text"/>	24 <input type="text"/>	<input type="text"/>	25 <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) (include dates if applicable) (255 characters accepted)

26

If it is known that the patient has ever received the requested or similar service(s), please explain (include dates) (255 characters accepted)

27

Please summarize the therapeutic goal to be met with the requested service(s) (255 characters accepted)

28

23. Use the **ICD-CM Type** drop-down list to select the ICD code type.
24. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
25. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
26. Enter a summary of the treatment and history of the patient in the **Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable** field.
27. Enter information regarding any similar services in the **If it is known that the patient has ever received the requested or similar service(s), please explain – include dates** field.
28. Enter a summary of the therapeutic goal to be met in the **Please summarize the therapeutic goal to be met with the requested service(s)** field.

Please list alternatives tried or considered and the reason why they are not feasible for this patient

Service Code	Describe Alternative Tried/Considered (30 characters accepted)
29 <input type="text"/>	30 <input type="text"/>
<input type="text"/>	Reason <input type="text"/> 31 <input type="text"/>
<input type="text"/>	Reason <input type="text"/>
<input type="text"/>	Reason <input type="text"/>
	Reason <input type="text"/>

Please explain why the least costly method of treatment is not being used. (255 characters accepted)

32

29. Enter the **Service Code** identifying a service that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
30. Enter details in the **Describe Alternative Tried/Considered** field. If an alternative service code has been entered in the adjacent field, leave the field blank.
31. Use the **Reason** drop-down list to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
32. Enter a summary of the treatment and history of the patient in the **Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable** field.

Attachment A Service

Incontinence Attachment Form (Attachment D)

Incontinence Supply Information

Please describe prognosis for controlling incontinence (255 characters accepted)

33

Please summarize treatment plan (255 characters accepted)

34

Please document need for multiple products (255 characters accepted)

35

33. Enter the description of the prognosis for controlling incontinence in the **Please describe prognosis for controlling incontinence** field.
34. Enter the summary of the incontinence treatment plan in the **Please summarize treatment plan** field.
35. Enter the need for multiple varieties of supplies in the **Please document need for multiple products** field.

* The following fields are required

TAR Required?	Service Code	Daily Usage	Unit Cost	Monthly Usage	Monthly Cost	Total Units	Total Cost
<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="text"/>						
<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="text"/>						
<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="text"/>						
<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="text"/>						
<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="text"/>						
<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="text"/>						

* # of Months Prescription Valid

* Generic Equivalents Prescribed? No Yes

- 36. Click the circular **TAR Required?** radio button to indicate if the prescribed product requires prior authorization. This replaces the need for submitting this information as an attachment. *Always required.
- 37. Enter the **Service Code** identifying the service being requested. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search. This replaces the need for submitting this information as an attachment. *Always required.
- 38. Enter the **Daily Usage** for the number of items to be used daily. This replaces the need for submitting this information as an attachment. *Always required.
- 39. Enter the **Unit Cost** of the product including markup and sales tax. This replaces the need for submitting this information as an attachment. *Always required.
- 40. Enter the **Monthly Usage** for the number of items to be used monthly. This replaces the need for submitting this information as an attachment. *Always required.
- 41. Enter the **Monthly Cost** of the product including markup and sales tax. This replaces the need for submitting this information as an attachment. *Always required.
- 42. Enter the **Total Units** to be used for the duration of the prescription. This replaces the need for submitting this information as an attachment. *Always required.
- 43. Enter the **Total Cost** over the duration of the prescription for this product including markup and sales tax. This replaces the need for submitting this information as an attachment. *Always required.

* The following fields are required

TAR Required?	Service Code	Daily Usage	Unit Cost	Monthly Usage	Monthly Cost	Total Units	Total Cost
<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="text"/>						
<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="text"/>						
<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="text"/>						
<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="text"/>						
<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="text"/>						
<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="text"/>						

* # of Months Prescription Valid * Generic Equivalents Prescribed?

44 45 No Yes

44. Use the **# of Months Prescription Valid** drop-down list to select the duration of the prescription in months. This replaces the need for submitting this information as an attachment. *Always required.

45. Click the circular **Generic Equivalents Prescribed?** radio button to indicate if the physician prescribed generic equivalent products. This replaces the need for submitting this information as an attachment. *Always required.

The screenshot shows a form titled "Prescribing Physician Information". It contains the following fields and elements:

- 46**: * Physician's License # (text input field)
- 47**: * Physician's Name (text input field)
- 48**: * Physician's Phone (text input field with format () -)
- 49**: * Prescription Date (text input field)
- Attachment A Attachment D Service (links)
- 50**: Continue (button)
- 51**: Another Service, Same Category (button)

46. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. This replaces the need for submitting this information as an attachment. *Always required.
47. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
48. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
49. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.
50. Click **Continue** to return to the TAR Services menu. See Module E for information on submitting the eTAR.
51. Click **Another Service, Same Category** to create another service line for the same service type.

Section 6. IV Equipment

DME

[eTAR Medical Tutorials](#)

Please Enter DME IV Equipment Information

[Attachment A](#)

Service Information

* **Service Code** (HCPCS Code) **Modifiers** (if applicable)

1 2

Service Description (40 characters accepted)

3

* **Total Units** **Sched.** *** Frequency**

4 5 /

Ant. Length of Need *** From Date** **Thru Date** *** Start of Care**

/ mmddyyyy mmddyyyy mmddyyyy

1. Enter the **Service Code** to identify the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search. *Always required.
2. Enter up to four **Modifiers**. If unknown, click the Modifier link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave the field blank.
4. Enter the **Total Units** requested. If requesting a rental, enter the number of rental months or days, depending on the service code entered. *Always required.
5. Use the **Sched.** drop-down list to select the appropriate details for the requested service. If "Other" is selected, enter the schedule in the Miscellaneous TAR Information field.

NOTE: The eTAR Medical Tutorials link is accessible from the upper right corner on all eTAR Medical webpages.

DME

eTAR Medical Tutorials

Please Enter DME IV Equipment Information

Attachment A

Service Information

* Service Code (HCPCS Code) Modifiers (if applicable)

Service Description (40 characters accepted)

* Total Units Sched. * Frequency /

Ant. Length of Need / * From Date mmddyyyy * Thru Date mmddyyyy * Start of Care mmddyyyy

- 6. Enter the **Frequency** for the number of units that will be used per time period. Enter the number of units in the first field and use the drop-down list to select the time period.
*Always required.

Example: If two units per day are needed, enter:

* Frequency / Day

- 7. Enter the **Ant. Length of Need** to indicate the appropriate period of the requested services. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the patient will need the services for one month, enter:

Ant. Length of Need / Month

- 8. Enter the **From Date** (mmddyyyy) for the requested start of service date.
* Always required.
- 9. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.

Ant. Length of Need <input type="text"/> / <input type="text"/>	* From Date mmddyyyy	Thru Date mmddyyyy	* Start of Care mmddyyyy
Pricing Override Request 11		Price 12	
* Place of Service 13			
Rendering Provider # 14			
*ICD-CM Type 15	*ICD Code (Decimal Required) 16	Diagnosis Description	Date of Onset mmddyyyy
Enter Miscellaneous TAR Information (500 characters accepted)			

10. Enter the **Start of Care** (mmddyyyy) date the patient began, or will begin, receiving the service requested. *Always required.
11. Use the **Pricing Override Request** drop-down list to select an override code for unlisted items or prices.
12. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
13. Use the **Place of Service** drop-down list to select the location where the service is being rendered. *Always required.
14. Enter a **Rendering Provider #** if rendering provider is different from submitting provider. This will allow another provider to inquire on eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
15. Use the **ICD-CM Type** drop-down list to select the ICD code type.
16. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.

NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.

Ant. Length of Need	* From Date	Thru Date	* Start of Care
<input type="text"/> / <input type="text"/> ▼	<input type="text" value="mmddyyyy"/>	<input type="text" value="mmddyyyy"/>	<input type="text" value="mmddyyyy"/>
Pricing Override Request		Price	
<input type="text"/> ▼		<input type="text"/>	
* Place of Service			
<input type="text"/> ▼			
Rendering Provider #			
<input type="text"/>			
*ICD-CM Type	*ICD Code (Decimal Required)	Diagnosis Description	Date of Onset
<input type="text"/> ▼	<input type="text"/>	<input type="text"/>	<input type="text" value="mmddyyyy"/>
Enter Miscellaneous TAR Information (500 characters accepted)			
<input type="text"/>			

17. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.

18. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Service

Patient assessment information for this Service (Attachment A)

Please list current **functional limitation** /physical condition codes

19

Please list current **medical status** codes relevant to requested service(s)

20

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
21 <input type="text"/>	22 <input type="text"/>	<input type="text"/>	23 <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

19. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes.
20. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes.
21. Use the **ICD-CM Type** drop-down list to select the ICD code type.
22. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.

NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
23. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.

Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) -- include dates if applicable. (255 characters accepted)

24

If it is known that the patient has ever received the requested or similar service(s), please explain -- include dates (255 characters accepted)

25

Please summarize the therapeutic goal to be met with the requested service(s). (255 characters accepted)

26

- 24. Enter a summary of the treatment and history of the patient in the **Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable** field.
- 25. Enter information regarding any similar services in the **If it is known that the patient has ever received the requested or similar service(s), please explain – include dates** field.
- 26. Enter a summary of the therapeutic goal to be met In the **Please summarize the therapeutic goal to be met with the requested service(s)** field.

Please list alternatives tried or considered and the reason why they are not feasible for this patient

Service Code	Describe Alternative Tried/Considered (30 characters accepted)
27	28
	Reason 29
	Reason
	Reason
	Reason

Please explain why the least costly method of treatment is not being used. (255 characters accepted)

30

27. Enter the **Service Code** identifying a service that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
28. Enter details in the **Describe Alternative Tried/Considered** field. If an alternative service code has been entered in the adjacent field, leave the field blank.
29. Use the **Reason** drop-down list to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
30. Enter a brief explanation in the **Please explain why the least costly method of treatment is not being used** field.

Prescribing Physician Information

* Physician Prescription (255 characters accepted)

31

* Physician's License #

32

* Physician's Name

33

* Physician's Phone

34

* Prescription Date

35

Attachment A Service

36 Continue

37 Another Service, Same Category

31. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. This replaces the need for submitting this information as an attachment. *Always required.
32. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. This replaces the need for submitting this information as an attachment. *Always required.
33. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
34. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
35. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.
36. Click **Continue** to return to the TAR Services menu. See Module E for information on submitting the eTAR.
37. Click **Another Service, Same Category** to create another service line for the same service type.

Section 7. Medical Supply

DME

[eTAR Medical Tutorials](#)

Please Enter DME Medical Supply Information

Attachment A

Service Information

* **Service Code** (HCPCS or Medical Supply Code) **Modifiers** (if applicable)

1 2

Service Description (40 characters accepted)

3

* **Total Units** **Quantity** **Frequency**

4 5 / /

Ant. Length of Need **From Date** **Thru Date** **Start of Care**

/ mmddyyyy mmddyyyy mmddyyyy

1. Enter the **Service Code** to identify the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search. *Always required.
2. Enter up to four **Modifiers**. If unknown, click the Modifier link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave the field blank.
4. Enter the **Total Units** requested. *Always required.
5. Enter the **Quantity** for the number of units to be used per time period. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If two units are anticipated to be used per month, enter:

* Quantity

/

NOTE: The eTAR Medical Tutorials are accessible from the upper right corner on all eTAR Medical webpages.

DME

eTAR Medical Tutorials

Please Enter DME Medical Supply Information

Attachment A Continue

Service Information

* **Service Code** (HCPCS or Medical Supply Code) **Modifiers** (if applicable)

Service Description (40 characters accepted)

* **Total Units** **Quantity** **Frequency**

/ /

Ant. Length of Need **From Date** **Thru Date** **Start of Care**

/

- 6. Enter the **Frequency** for the number of units that will be used per time period. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If three units per day are needed, enter:

* Frequency

/

- 7. Enter the **Ant. Length of Need** to indicate the appropriate period of the requested services. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the patient will need the services for six months, enter:

Ant. Length of Need

/

- 8. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive.
- 9. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.

Ant. Length of Need <input type="text"/> / <input type="text"/> ▼	From Date <input type="text" value="mmddyyyy"/>	Thru Date <input type="text" value="mmddyyyy"/>	Start of Care <input type="text" value="mmddyyyy"/> 10
Price Override <input type="text"/> ▼ 11		Price <input type="text"/> 12	
* Place of Service <input type="text"/> ▼ 13			
Rendering Provider # <input type="text"/> 14			
*ICD-CM Type <input type="text"/> ▼ 15	*ICD Code (Decimal Required) <input type="text"/>	Diagnosis Description <input type="text"/>	Date of Onset <input type="text" value="mmddyyyy"/>
Enter Miscellaneous TAR Information (500 characters accepted) <input type="text"/>			

10. Enter the **Start of Care** (mmddyyyy) date the patient began, or will begin, receiving the service requested.
11. Use the **Price Override** drop-down list to select an override code for unlisted items or prices.
12. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
13. Use **Place of Service** the drop-down list to select the location where the service is being rendered. *Always required.
14. Enter a **Rendering Provider #** if rendering provider is different from submitting provider. This will allow another provider to inquire on eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
15. Use the **ICD-CM Type** drop-down list to select the ICD code type.

Ant. Length of Need <input type="text"/> / <input type="text"/> ▼	From Date <input type="text" value="mmddyyyy"/>	Thru Date <input type="text" value="mmddyyyy"/>	Start of Care <input type="text" value="mmddyyyy"/>
Price Override <input type="text"/> ▼	Price <input type="text"/>		
* Place of Service <input type="text"/> ▼			
Rendering Provider # <input type="text"/>			
*ICD-CM Type <input type="text"/> ▼	*ICD Code (Decimal Required) <input type="text" value="16"/>	Diagnosis Description <input type="text"/>	Date of Onset <input data-bbox="1247 625 1286 655" type="text" value="17"/> <input type="text" value="mmddyyyy"/>
Enter Miscellaneous TAR Information (500 characters accepted) <input type="text" value="18"/>			

16. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.

NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.

17. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.

18. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Service Continue

Patient assessment information for this Service (Attachment A)

P.O.T. Adherence In-Home Assistance/Care Giver

19

20 Hrs/Day Days/Wk

Please list current **functional limitation** /physical condition codes

21

Please list previous **functional limitation** /physical condition codes

22

Please list current **medical status** codes relevant to requested service(s)

23

19. Use the **P.O.T Adherence** drop-down list to select the level of compliance the patient has to the Plan of Treatment.
20. Enter the amount of hours per day and days per week assistance is available to the patient in his or her home in the **In-Home Assistance/Care Giver** field.
21. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes.
22. Enter the previous functional limitation or physical condition relative to the requested services in the **Please list previous functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes.
23. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes.

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
24	25		26

Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) -- include dates if applicable. (255 characters accepted)

27

If it is known that the patient has ever received the requested or similar service(s), please explain -- include dates. (255 characters accepted)

28

Please summarize the therapeutic goal to be met with the requested service(s). (255 characters accepted)

29

24. Use the **ICD-CM Type** drop-down list to select the ICD code type.
25. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
26. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
27. Enter a summary of the treatment and history of the patient in the **Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable** field.
28. Enter information regarding any similar services in the **If it is known that the patient has ever received the requested or similar service(s), please explain – include dates** field.
29. Enter a summary of the therapeutic goal to be met in the **Please summarize the therapeutic goal to be met with the requested service(s)** field.

Please list alternatives tried or considered and the reason why they are not feasible for this patient

Service Code	Describe Alternative Tried/Considered (30 characters accepted)
30	31
	Reason 32
	Reason
	Reason
	Reason

Please explain why the least costly method of treatment is not being used. (255 characters accepted)

33

30. Enter the **Service Code** identifying a service that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
31. Enter details in the **Describe Alternative Tried/Considered** field. If an alternative service code has been entered in the adjacent field, leave the field blank.
32. Use the **Reason** drop-down list to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
33. Enter a brief explanation in the **Please explain why the least costly method of treatment is not being used** field.

The screenshot shows a web form titled "Prescribing Physician Information". It contains several input fields and two buttons. The fields are: a large text area for "Physician Prescription" (255 characters accepted), a text box for "Physician's License #", a text box for "Physician's Name", a three-part text box for "Physician's Phone", and a text box for "Prescription Date". At the bottom, there are two buttons: "Continue" and "Another Service, Same Category".

34 * Physician Prescription (255 characters accepted)

35 * Physician's License #

36 * Physician's Name

37 * Physician's Phone

38 * Prescription Date

Attachment A Service

39 Continue 40 Another Service, Same Category

34. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. This replaces the need for submitting this information as an attachment. *Always required.
35. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. This replaces the need for submitting this information as an attachment. *Always required.
36. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
37. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
38. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.
39. Click **Continue** to return to the TAR Service menu. See Module E for information on submitting the eTAR.
40. Click **Another Service, Same Category** to create another service line for the same service type.

Section 8. Mobility

[eTAR Medical Tutorials](#)

Please Enter DME Mobility Information

[Attachment A](#) [Attachment B](#)

Service Information

* **Service Code** (HCPCS Code) **Modifiers** (if applicable)

Service Description (40 characters accepted) **Side**

* **Total Units** **Frequency** **Ant. Length of Need**

 / /

From Date **Thru Date** **Start of Care** **Discharge Date**

1. Enter the **Service Code** to identify the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search. *Always required.
2. Enter up to four **Modifiers**. If unknown, click the Modifier link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave the field blank.
4. Use the **Side** drop-down list to select Right, Left or Bilateral.
5. Enter the **Total Units** requested. If requesting a rental, enter the number of rental months. *Always required.

NOTE: The eTAR Medical Tutorials are accessible from the upper right corner on all eTAR Medical webpages.

DME

eTAR Medical Tutorials

Please Enter DME Mobility Information

Attachment A Attachment B Continue

Service Information

* Service Code (HCPCS Code) Modifiers (if applicable)

Service Description (40 characters accepted) Side

* Total Units Frequency Ant. Length of Need

From Date Thru Date Start of Care Discharge Date

mmddyyyy mmddyyyy mmddyyyy mmddyyyy

- 6. Enter the **Frequency** for the number of units that will be used per time period. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the service will be used five hours per day, enter:

* Frequency

5 / Day

- 7. Enter the **Ant. Length of Need** to indicate the appropriate period of the requested services. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the patient will need the services for two months, enter:

* Ant. Length of Need

2 / Month

- 8. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive.
- 9. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.

From Date mmddyyyy	Thru Date mmddyyyy	Start of Care 10 mmddyyyy	Discharge Date 11 mmddyyyy
Admit From 12			
Discharge 13			
* Place Of Service 14			
*ICD-CM Type 15	*ICD Code (Decimal Required) 16	Diagnosis Description	Date of Onset mmddyyyy

10. Enter the **Start of Care** (mmddyyyy) date the patient began, or will begin, receiving the service requested.
11. Enter the **Discharge Date** (mmddyyyy). If Discharge has been selected, this field is required.
12. Use the **Admit From** drop-down list to select the level of care from where the patient was admitted.
13. Use the **Discharge** drop-down list to select the level of care for the patient.
14. Use **Place of Service** the drop-down list to select the location where the service is being rendered. *Always required.
15. Use the **ICD-CM Type** drop-down list to select the ICD code type.
16. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.

NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.

The screenshot displays a form with the following fields and labels:

- *ICD-CM Type**: A dropdown menu.
- *ICD Code (Decimal Required)**: A text input field.
- Diagnosis Description**: A large text input field.
- Date of Onset**: A text input field with a placeholder 'mmddyyyy' and a circled number 17.
- Rendering Provider #**: A text input field with a circled number 18.
- Pricing Override Request**: A dropdown menu with a circled number 19.
- Price**: A text input field with a circled number 20.
- MSRP**: A text input field with a circled number 21.
- Enter Miscellaneous TAR Information (500 characters accepted)**: A large text area with a circled number 22.

17. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
18. Enter a **Rendering Provider #** if rendering provider is different from submitting provider. This will allow another provider to inquire on eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
19. Use the **Pricing Override Request** drop-down list to select an override code for unlisted items or prices.
20. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
21. Enter the **MSRP** (Manufacturer's Suggested Retail Price) or actual invoice price for the service being requested, up to seven digits.
22. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Attachment B Service

Patient assessment information for this Service (Attachment A)

P.O.T. Adherence Feeding Method

In-Home Assistance/Care Giver Hrs/Day Days/Wk Height . " Weight lbs. oz.

23. Use the **P.O.T Adherence** drop-down list to select the level of compliance the patient has to the Plan of Treatment.
24. Use the **Feeding Method** drop-down list to select the method of feeding for the patient.
25. Enter the amount of hours per day and days per week assistance is available to the patient in his or her home in the **In-Home Assistance/Care Giver** field.
26. Enter the patient's **Height** in feet and inches.
27. Enter the patient's **Weight** in pounds and ounces.

* Please list current **functional limitation** /physical condition codes

28

Please list previous **functional limitation** /physical condition codes

29

Please list current **medical status** codes relevant to requested service(s)

30

28. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes. This replaces the need for submitting this information as an attachment.
*Always required.
29. Enter the previous functional limitation or physical condition relative to the requested services in the **Please list previous functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes.
30. Enter current medical status codes which describe the patient’s condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes.

*ICD-CM Type	*ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
31 <input type="text"/>	32 <input type="text"/>	<input type="text"/>	33 <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) -- include dates if applicable. (255 characters accepted)			
34 <input type="text"/>			
If it is known that the patient has ever received the requested or similar service(s), please explain -- include dates. (255 characters allowed)			
35 <input type="text"/>			
Please summarize the therapeutic goal to be met with the requested service(s). (255 characters allowed)			
36 <input type="text"/>			

31. Use the **ICD-CM Type** drop-down list to select the ICD code type.
32. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
33. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
34. Enter a summary of the treatment and history of the patient in the **Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include date** field.
35. Enter information regarding any similar services in the **If it is known that the patient has ever received the requested or similar service(s), please explain – include dates** field.
36. Enter a summary of the therapeutic goal to be met in the **Please summarize the therapeutic goal to be met with the requested service(s)** field.

Please list alternatives tried or considered and the reason why they are not feasible for this patient

Service Code	Describe Alternative Tried/Considered (30 characters accepted)
<input type="text"/>	<input type="text"/>
<input type="text"/>	Reason <input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	Reason <input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	Reason <input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	Reason <input type="text"/>

Please explain why the least costly method of treatment is not being used. (255 characters allowed)

- 37. Enter the **Service Code** identifying a service that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
- 38. Enter details in the **Describe Alternative Tried/Considered** field. If an alternative service code has been entered in the adjacent field, leave the field blank.
- 39. Use the **Reason** drop-down list to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
- 40. Enter a brief explanation in the **Please explain why the least costly method of treatment is not being used** field.

Prescribing Physician Information

* Physician Prescription (255 characters accepted)

41

* Physician's License #

42

* Physician's Name

43

* Physician's Phone

44

* Prescription Date

45

41. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. This replaces the need for submitting this information as an attachment. *Always required.
42. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. This replaces the need for submitting this information as an attachment. *Always required.
43. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
44. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
45. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.

Attachment A Service

DME Attachment Form (Attachment B)

* Replacement?
 46 No Yes

Replace Reason
 47

Unlisted Reason
 48

* Home Accessible?
 49 No Yes

* Safe Operation?
 50 No Yes

* Indep. Operation?
 51 No Yes

Specific Comments (150 characters allowed)
 52

46. Click the circular **Replacement?** radio button to indicate whether the requested service is a replacement of a previous item received or authorized for the patient. This replaces the need for submitting this information as an attachment. *Always required.
47. If the circular Replacement radio button is selected as “Yes,” use the **Replacement Reason** drop-down lists to select up to three reasons why the item previously received or authorized for the patient is being replaced.
48. If the service requested is for an unlisted code, use the **Unlisted Reason** drop-down lists to select up to three reasons why a listed code cannot be used in place of the unlisted code.
49. Click the circular **Home Accessible?** radio button to indicate if the patient’s home is accessible for the Equipment. This replaces the need for submitting this information as an attachment. *Always required.
50. Click the circular **Safe Operation?** radio button to indicate if the patient is able to operate the equipment requested safely. This replaces the need for submitting this information as an attachment. *Always required.
51. Click the circular **Independent Operation?** radio button to indicate if the patient is able to operate the equipment requested independently. This replaces the need for submitting this information as an attachment. *Always required.
52. Enter **Specific Comments** explaining why the particular item, device, accessory is needed for the patient. For repairs or replacements, explain why an existing warranty does not cover the service.

Equipment Already in Home

Item	Usage (Hrs/Day)
<input type="text" value="53"/> ▼	<input type="text" value="54"/>
<input type="text" value="53"/> ▼	<input type="text"/>
<input type="text" value="53"/> ▼	<input type="text"/>
<input type="text" value="53"/> ▼	<input type="text"/>
<input type="text" value="53"/> ▼	<input type="text"/>

<input type="text" value="55"/> mmddyyyy	<input type="text" value="56"/> mmddyyyy
--	--

53. Use the **Item** drop-down lists to select the equipment already present in the home relevant to the requested service.
54. Enter the **Usage** for the average number of hours per day the patient uses the equipment.
55. Enter the **Trial Begin Date** (mmddyyyy).
56. Enter the **Trial End Date** (mmddyyyy).

The screenshot shows a web form with the following elements:

- 57**: Results (drop-down menu)
- 58**: Serial # (text input)
- 59**: Manufacturer (text input)
- 60**: Model (text input)
- 61**: Purchase Date (text input, format: mmddyyyy)
- 62**: Purchased By (drop-down menu)
- 63**: Warranty Expire Date (text input, format: mmddyyyy)
- Attachment A**, **Attachment B**, **Service** (links)
- 64**: Continue (button)
- 65**: Another Service, Same Category (button)

57. Use the **Results** drop-down list to select the results of the trial period.
58. Enter the **Serial #** of the product.
59. Enter the **Manufacturer** of the equipment.
60. Enter the **Model** or stock number identifying the equipment.
61. Enter the original **Purchase Date** (mmddyyyy) for repair or replacements. Otherwise, leave the field blank.
62. If Purchase Date is entered, use the **Purchased By** drop-down list to select the original purchaser of the equipment.
63. Enter the **Warranty Expire Date** (mmddyyyy) for the equipment. If later than the request date, an explanation or medical justification of why the warranty does not cover repair or replacement must be entered in Miscellaneous TAR Information.
64. Click **Continue** to return to the TAR Services menu. See Module E for information on submitting the eTAR.
65. Click **Another Service, Same Category** to create another service line for the same service type.

Section 9. Orthotics/Prosthetics

DME

eTAR Medical Tutorials

Please Enter Orthotics/Prosthetics Information

Attachment A Attachment B

Service Information

* Service Code (HCPCS Code) Modifiers (if applicable)

1 2

Service Description (40 characters accepted) * Side

3 4

* Total Units Quantity Frequency

5 6 / /

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search. *Always required.
2. Enter up to four **Modifiers**. If unknown, click the Modifier link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave the field blank.
4. Use the **Side** drop-down list to select Right, Left or Bilateral. *Always required.
5. Enter the **Total Units** requested. *Always required.
6. If compression stockings or burn garments are being requested, enter the **Quantity** for the number of units that will be used per time period. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If it is expected that four stockings will be used per month, enter:

* Quantity

4 / Month

NOTE: The eTAR Medical Tutorials link is accessible from the upper right corner on all eTAR Medical webpages.

The screenshot shows a form with the following fields and callouts:

- * Total Units**: Input field.
- Quantity**: Input field followed by a dropdown menu.
- Frequency**: Input field followed by a dropdown menu, with callout 7.
- Ant. Length of Need**: Input field followed by a dropdown menu, with callout 8.
- From Date**: Input field with the format 'mmddyyyy', with callout 9.
- Thru Date**: Input field with the format 'mmddyyyy', with callout 10.
- Place Of Service**: Dropdown menu, with callout 11.
- Rendering Provider #**: Input field, with callout 12.

7. If compression stockings or burn garments are being requested, enter the **Frequency** for the number of items that will be used per time period. Enter the number of hours in the first field, and use the drop-down list to select the time period.

Example: If the item will be used five hours per day, enter:

* Frequency
5 / Day

8. Enter the **Ant. Length of Need** to indicate the appropriate period of the requested services. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the patient will need the services for two months, enter:

* Ant. Length of Need
2 / Month

9. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive.

10. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.

11. Use **Place of Service** the drop-down list to select the location where the service is being rendered.

12. Enter a **Rendering Provider #** if rendering provider is different from submitting provider. This will allow another provider to inquire on eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.

The screenshot shows a form titled "Pricing Override Request" with the following fields and labels:

- 13** Pricing Override Request (drop-down menu)
- 14** Price (text input)
- 15** *ICD-CM Type (drop-down menu)
- 16** *ICD Code (Decimal Required) (text input)
- Diagnosis Description (text input)
- 17** Date of Onset (text input with mask mmddyyyy)
- 18** Enter Miscellaneous TAR Information (500 characters accepted) (text area)

13. Use the **Pricing Override Request** drop-down list to select an override code for unlisted items or prices.
14. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
15. Use the **ICD-CM Type** drop-down list to select the ICD code type.
16. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
17. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
18. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Attachment B Service

Patient assessment information for this Service (Attachment A)

* P.O.T. Adherence

Height ' "

Weight lbs. oz.

* Please list current [functional limitation](#) /physical condition codes

* Please list previous [functional limitation](#) /physical condition codes

* Please list current [medical status](#) codes relevant to requested service(s)

19. Use the **P.O.T Adherence** drop-down list to select the level of compliance the patient has to the Plan of Treatment. This replaces the need for submitting this information as an attachment. *Always required.
20. Enter the patient's **Height** in feet and inches.
21. Enter the patient's **Weight** in pounds and ounces.
22. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes. This replaces the need for submitting this information as an attachment. *Always required.
23. Enter the previous functional limitation or physical condition relative to the requested services in the **Please list previous functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes. See Appendix B for a list of functional limitation codes. This replaces the need for submitting this information as an attachment. *Always required.
24. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes. This replaces the need for submitting this information as an attachment. *Always required.

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
25 <input type="text"/>	26 <input type="text"/>	<input type="text"/>	27 <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) -- include dates if applicable. (255 characters accepted)			
28 <input type="text"/>			
* If it is known that the patient has ever received the requested or similar service(s), please explain -- include dates. (255 characters accepted)			
29 <input type="text"/>			
Please summarize the therapeutic goal to be met with the requested service(s). (255 characters accepted)			
30 <input type="text"/>			

25. Use the **ICD-CM Type** drop-down list to select the ICD code type.
26. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
27. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
28. Enter a summary of the treatment and history of the patient in the **Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable** field.
29. Enter information regarding any similar services in the **If it is known that the patient has ever received the requested or similar service(s), please explain – include dates** field. This replaces the need for submitting this information as an attachment.
*Always required.
30. Enter a summary of the therapeutic goal to be met in the **Please summarize the therapeutic goal to be met with the requested service(s)** field.

Please list alternatives tried or considered and the reason why they are not feasible for this patient

Service Code	Describe Alternative Tried/Considered (30 characters accepted)
31	32
	Reason 33
	Reason
	Reason
	Reason

Please explain why the least costly method of treatment is not being used. (255 characters accepted)

34

31. Enter the **Service Code** identifying a service that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
32. Enter details in the **Describe Alternative Tried/Considered** field. If an alternative service code has been entered in the adjacent field, leave the field blank.
33. Use the **Reason** drop-down list to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
34. Enter a brief explanation in the **Please explain why the least costly method of treatment is not being used** field.

Prescribing Physician Information

* Physician Prescription (255 characters accepted)

35

* Physician's License #

36

* Physician's Name

37

* Physician's Phone

38

* Prescription Date

39

35. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. This replaces the need for submitting this information as an attachment. *Always required.
36. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. This replaces the need for submitting this information as an attachment. *Always required.
37. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
38. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
39. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.

The screenshot displays the 'DME Attachment Form (Attachment B)' interface. At the top, there is a header 'Attachment A Service' and a 'Continue' button. Below this, the form title 'DME Attachment Form (Attachment B)' is shown. The main section contains several fields:

- 40**: A radio button group for '* Replacement?' with 'No' selected.
- 41**: A drop-down menu for 'Replacement Reason'.
- 42**: A drop-down menu for 'Unlisted Reason'.
- 43**: A radio button group for 'Home Accessible?' with 'No' selected.
- 44**: A text area for 'Specific Comments (150 characters accepted)'.

At the bottom, there is a footer 'Attachment A Service' and two buttons: 'Continue' (labeled **45**) and 'Another Service, Same Category' (labeled **46**).

40. Click the circular **Replacement?** radio button to indicate whether the requested service is a replacement of a previous item received or authorized for the patient. This replaces the need for submitting this information as an attachment. *Always required.
41. If the circular Replacement radio button is selected as “Yes,” use the **Replacement Reason** drop-down lists to select up to three reasons why the item previously received or authorized for the patient is being replaced.
42. If the service requested is for an unlisted code, use the **Unlisted Reason** drop-down lists to select up to three reasons why a listed code cannot be used in place of the unlisted code.
43. Click the circular **Home Accessible?** radio button to indicate if the patient’s home is accessible for the Equipment. This replaces the need for submitting this information as an attachment. *Always required.
44. Enter **Specific Comments** explaining why the particular item, device or accessory is needed for the patient. For repairs or replacements, explain why an existing warranty does not cover the service.
45. Click **Continue** once to return to the TAR Services menu. See Module E for information on submitting the eTAR.
46. Click **Another Service, Same Category** to create another service line for the same service type.

Section 10. Oxygen Respiratory Equipment

DME

eTAR Medical Tutorials

Please Enter Oxygen Respiratory Equipment Information

[Attachment A](#) [Attachment B](#)

Service Information

* **Service Code** (HCPCS Code) **Modifiers** (if applicable)

1 2

Service Description (40 characters accepted)

3

* **Total Units** * **Quantity** **Frequency**

4 5 /

1. Enter the **Service Code** to identify the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
*Always required.
2. Enter up to four **Modifiers**. If unknown, click the Modifier link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave the field blank.
4. Enter the **Total Units** requested. *Always required.
5. Enter the **Quantity** for the number of units to be used per week or month. Enter the number of days in the first field and use the drop-down list to select the time period.
*Always required.

Example: If 20 units are anticipated to be used per month, enter:

* Quantity

20 / Month

NOTE: The eTAR Medical Tutorials are accessible from the upper right corner on all eTAR Medical webpages.

The screenshot shows a form with the following fields and labels:

- * Total Units**: Input field
- * Quantity**: Input field followed by a dropdown menu
- Frequency**: Input field (circled 6) followed by a dropdown menu
- Ant. Length of Need**: Input field (circled 7) followed by a dropdown menu
- From Date**: Input field (circled 8) with placeholder 'mmddyyyy'
- Thru Date**: Input field (circled 9) with placeholder 'mmddyyyy'
- * Start of Care**: Input field (circled 10) with placeholder 'mmddyyyy'
- Discharge Date**: Input field (circled 11) with placeholder 'mmddyyyy'
- Discharge**: Dropdown menu
- * Place of Service**: Dropdown menu

6. Enter the **Frequency** for the number of hours per day the service will be used. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the service will be used five hours per day, enter:

* Frequency
5 / Day

7. Enter the **Ant. Length of Need** to indicate the appropriate period of the requested services. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the patient will need the services for two months, enter:

* Ant. Length of Need
2 / Month

8. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive.
9. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.
10. Enter the **Start of Care** (mmddyyyy) date the patient began, or will begin, receiving the service requested. *Always required.
11. Enter the **Discharge Date** (mmddyyyy). If Discharge has been selected, the field is required.

The screenshot displays a form with the following fields and labels:

- 12** Discharge: A drop-down menu.
- 13** * Place of Service: A drop-down menu.
- 14** Rendering Provider #: A text input field.
- 15** Price Override: A drop-down menu.
- 16** Price: A text input field.
- 17** MSRP: A text input field.
- *ICD-CM Type: A drop-down menu.
- * ICD Code (Decimal Required): A text input field.
- Diagnosis Description: A text input field.
- Date of Onset: A text input field with the format mmddyyyy.
- Enter Miscellaneous TAR Information (500 characters accepted): A large text area with a vertical scrollbar.

12. Use the **Discharge** drop-down list to select the level of care for the patient.
13. Use **Place of Service** the drop-down list to select the location where the service is being rendered. *Always required.
14. Enter a **Rendering Provider #** if rendering provider is different from the submitting provider. This will allow another provider to inquire on eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
15. Use the **Price Override** drop-down list to select an override code for unlisted items or prices.
16. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
17. Enter the **MSRP** (Manufacturer's Suggested Retail Price) or actual invoice price for the service being requested, up to seven digits.

The screenshot shows a web form with the following fields and labels:

- Discharge: A dropdown menu.
- * Place of Service: A dropdown menu.
- Rendering Provider #: A text input field.
- Price Override: A dropdown menu.
- Price: A text input field.
- MSRP: A text input field.
- *ICD-CM Type: A dropdown menu, circled with '18'.
- * ICD Code (Decimal Required): A text input field, circled with '19'.
- Diagnosis Description: A text input field.
- Date of Onset: A text input field with the format 'mmddyyyy', circled with '20'.
- Enter Miscellaneous TAR Information (500 characters accepted): A large text area, circled with '21'.

- 18. Use the **ICD-CM Type** drop-down list to select the ICD code type.
- 19. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
- 20. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
- 21. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Attachment B Service Continue

Patient assessment information for this Service (Attachment A)

Height Weight

22 , "

23 lbs. oz.

Please list current **functional limitation** /physical condition codes

24

Please list previous **functional limitation** /physical condition codes

25

Please list current **medical status** codes relevant to requested service(s)

26

22. Enter the patient's **Height** in feet and inches.

23. Enter the patient's **Weight** in pounds and ounces.

24. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes.

25. Enter the previous functional limitation or physical condition relative to the requested services in the **Please list previous functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes.

26. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes.

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
27 <input type="text"/>	28 <input type="text"/>	<input type="text"/>	29 <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) -- include dates if applicable. (255 characters accepted)

30

If it is known that the patient has ever received the requested or similar service(s), please explain -- include dates. (255 characters accepted)

31

Please summarize the therapeutic goal to be met with the requested service(s). (255 characters accepted)

32

27. Use the **ICD-CM Type** drop-down list to select the ICD code type.
28. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
29. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
30. Enter a summary of the treatment and history of the patient in the **Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable** field.
31. Enter information regarding any similar services in the **If it is known that the patient has ever received the requested or similar service(s), please explain – include dates** field.
32. Enter a summary of the therapeutic goal to be met in the **Please summarize the therapeutic goal to be met with the requested service(s)** field.

Please list alternatives tried or considered and the reason why they are not feasible for this patient

Service Code	Describe Alternative Tried/Considered (30 characters accepted)
33	34
	Reason 35
	Reason
	Reason
	Reason

Please explain why the least costly method of treatment is not being used. (255 characters accepted)

36

33. Enter the **Service Code** identifying a service that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
34. Enter details in the **Describe Alternative Tried/Considered** field. If an alternative service code has been entered in the adjacent field, leave the field blank.
35. Use the **Reason** drop-down list to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
36. Enter a brief explanation in the **Please explain why the least costly method of treatment is not being used** field.

- 37. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. This replaces the need for submitting this information as an attachment. *Always required.
- 38. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. This replaces the need for submitting this information as an attachment. *Always required.
- 39. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
- 40. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
- 41. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.

Attachment A Service

DME Attachment Form (Attachment B)

* Replacement? 42
 No Yes

Replacement Reason 44

* Safe Operation? 43
 No Yes

Unlisted Reason 45

Specific Comments (150 characters accepted) 46

42. Click the circular **Replacement?** radio button to indicate whether the requested service is a replacement of a previous item received or authorized for the patient. This replaces the need for submitting this information as an attachment. *Always required.
43. Click the circular **Safe Operation?** radio button to indicate if the patient is able to operate the equipment requested safely. This replaces the need for submitting this information as an attachment. *Always required.
44. If the circular Replacement radio button is selected as “Yes,” use the **Replacement Reason** drop-down lists to select up to three reasons why the item previously received or authorized for the patient is being replaced.
45. If the service requested is for an unlisted code, use the **Unlisted Reason** drop-down lists to select up to three reasons why a listed code cannot be used in place of the unlisted code.
46. Enter **Specific Comments** explaining why the particular item, device, accessory is needed for the patient. For repairs or replacements, explain why an existing warranty does not cover the service.

The screenshot shows a web form with the following fields and callouts:

- 47**: Blood Gas Analysis Date (mmddyyyy)
- 48**: pH
- 49**: PCO2
- 50**: PO2
- 51**: O2 Liter Flow
- 52**: Hemoglobin
- 53**: Hematocrit
- 54**: Trial Begin Date (mmddyyyy)
- 55**: Trial End Date (mmddyyyy)
- Results (dropdown menu)
- Serial # (text box)
- Manufacturer (text box)
- Model (text box)
- Purchase Date (mmddyyyy)
- Purchased By (dropdown menu)
- Warranty Expire Date (mmddyyyy)
- Attachment A Attachment B Service (links)
- Continue (button)
- Another Service, Same Category (button)

47. Enter the **Blood Gas Analysis Date** (mmddyyyy) when the blood gas analysis was performed.
48. Enter the **pH** score from the blood gas analysis performed on the blood gas analysis date, including the decimal point.
49. Enter the **PCO2** score from the blood gas analysis performed on the blood gas analysis date, including the decimal point.
50. Enter the **PO2** score form the blood gas analysis performed on the blood gas analysis date, including the decimal point.
51. Enter the liters of oxygen to be used per minute by the patient, including the decimal point for oxygen requests in the **O2 Liter Flow** field.
52. Enter the **Hemoglobin** lab score from the test taken on the blood gas analysis date, excluding the decimal point.
53. Enter the **Hematocrit** lab score from the test taken on the blood gas analysis date, excluding the decimal point.
54. Enter the **Trial Begin Date** (mmddyyyy).
55. Enter the **Trial End Date** (mmddyyyy).

Blood Gas Analysis Date <input type="text" value="mmddyyyy"/>	pH <input type="text"/>	PCO2 <input type="text"/>	PO2 <input type="text"/>	O2 Liter Flow <input type="text"/>
Hemoglobin <input type="text"/>	Hematocrit <input type="text"/>			
Trial Begin Date <input type="text" value="mmddyyyy"/>	Trial End Date <input type="text" value="mmddyyyy"/>	Results <input type="text" value="56"/>		
Serial # <input type="text" value="57"/>	Manufacturer <input type="text" value="58"/>	Model <input type="text" value="59"/>		
Purchase Date <input type="text" value="mmddyyyy"/>	Purchased By <input type="text" value="61"/>	Warranty Expire Date <input type="text" value="mmddyyyy"/>		
Attachment A Attachment B Service		<input type="button" value="63 Continue"/> <input type="button" value="64 Another Service, Same Category"/>		

56. Use the **Results** drop-down list to select the results of the trial period.
57. Enter the **Serial #** of the product.
58. Enter the **Manufacturer** of the equipment.
59. Enter the **Model** or stock number identifying the equipment.
60. Enter the original **Purchase Date** (mmddyyyy) for repair or replacements. Otherwise, leave the field blank.
61. If Purchase Date is entered, use the **Purchased By** drop-down list to select the original purchaser of the equipment.
62. Enter the **Warranty Expire Date** (mmddyyyy) for the equipment. If later than the request date, an explanation or medical justification of why the warranty does not cover repair or replacement must be entered in Miscellaneous TAR Information.
63. Click **Continue** to return to the TAR Services menu. See Module E for information on submitting the eTAR.
64. Click **Another Service, Same Category** to create another service line for the same service type.

Section 11. DME Pumps (Non-IV)

DME

[eTAR Medical Tutorials](#)

Please Enter DME Pumps (non-IV) Information

[Attachment A](#)
[Attachment B](#)

Service Information

* **Service Code** (HCPCS Code) **Modifiers** (if applicable)

Service Description (40 characters accepted)

* **Total Units** **From Date** **Thru Date** **Start of Care**

Schedule

1. Enter the **Service Code** to identify the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search. *Always required.
2. Enter up to four **Modifiers**. If unknown, click the Modifier link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave the field blank.
4. Enter the **Total Units** requested. If requesting a rental, enter the number of rental months or days. *Always required.
5. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive.
6. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.
7. Enter the **Start of Care** (mmddyyyy) date the patient began, or will begin, receiving the service requested.

NOTE: The eTAR Medical Tutorials are accessible from the upper right corner on all eTAR Medical webpages.

The screenshot shows a form with the following fields and labels:

- Schedule**: A drop-down menu with a blue arrow icon, circled with the number 8.
- Frequency**: A text input field followed by a slash and a drop-down menu with a blue arrow icon, circled with the number 9.
- Ant. Length of Need**: A text input field followed by a slash and a drop-down menu with a blue arrow icon, circled with the number 10.
- Rendering Provider #**: A text input field, circled with the number 11.
- Pricing Override Request**: A drop-down menu with a blue arrow icon, circled with the number 12.
- Price**: A text input field, circled with the number 13.
- * POS**: A drop-down menu with a blue arrow icon.

8. Use the **Schedule** drop-down list to select the appropriate details for the requested service. If Other is selected, enter the schedule in the Enter Miscellaneous TAR Information field.
9. Enter the **Frequency** for the number of units that will be used per time period. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the equipment will be used three times per week, enter:

* Frequency
3 / Week

10. Enter the **Ant. Length of Need** to indicate the appropriate period of the requested services. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the patient will need services for one month, enter:

Ant. Length of Need
1 / Month

11. Enter a **Rendering Provider #** if rendering provider is different from the submitting provider. This will allow another provider to inquire on eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
12. Use the **Pricing Override Request** drop-down list to select an override code for unlisted items or prices.
13. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.

The screenshot displays a web form with the following elements:

- Field 14:** A drop-down menu labeled "* POS".
- Field 15:** A drop-down menu labeled "*ICD-CM Type (Required)".
- Field 16:** A text input field labeled "*ICD Code (Decimal)".
- Field 17:** A text input field labeled "Date of Onset" with a placeholder "mmddyyyy".
- Field 18:** A large text area labeled "Enter Miscellaneous TAR Information (500 characters accepted)".

14. Use the **POS** drop-down list to select the location where the service is being rendered.
*Always required.
15. Use the **ICD-CM Type** drop-down list to select the ICD code type.
16. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
17. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
18. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Attachment B Service

Patient assessment information for this Service (Attachment A)

P.O.T. Adherence

Feeding Method

In-Home Assistance/Care Giver Hrs/Day Days/Wk

Height ' "

Weight lbs. oz.

Please list current **functional limitation** /physical condition codes

* Please list current **medical status** codes relevant to requested service

19. Use the **P.O.T Adherence** drop-down list to select the level of compliance the patient has to the Plan of Treatment.
20. Use the **Feeding Method** drop-down list to select the method of feeding for the patient.
21. Enter the amount of hours per day and days per week assistance is available to the patient in his or her home in the **In-Home Assistance/Care Giver** field.
22. Enter the patient's **Height** in feet and inches.
23. Enter the patient's **Weight** in pounds and ounces.
24. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes.
25. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes. This replaces the need for submitting this information as an attachment.
*Always required.

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
26 <input type="text"/>	27 <input type="text"/>	<input type="text"/>	28 <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) -- include dates if applicable. (255 characters accepted)			
29 <input type="text"/>			
If it is known that the patient has ever received the requested or similar service(s), please explain -- include dates. (255 characters accepted)			
30 <input type="text"/>			
Please summarize the therapeutic goal to be met with the requested service(s).(255 characters accepted)			
31 <input type="text"/>			

26. Use the **ICD-CM Type** drop-down list to select the ICD code type.
27. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
28. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
29. Enter a summary of the treatment and history of the patient in the **Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable** field.
30. Enter information regarding any similar services in the **If it is known that the patient has ever received the requested or similar service(s), please explain – include dates** field.
31. Enter a summary of the therapeutic goal to be met in the **Please summarize the therapeutic goal to be met with the requested service(s)** field.

Please list alternatives tried or considered and the reason why they are not feasible for this patient

Service Code	Describe Alternative Tried/Considered (30 characters accepted)
32	33
	Reason 34
	Reason
	Reason
	Reason

Please explain why the least costly method of treatment is not being used. (255 characters accepted)

35

32. Enter the **Service Code** identifying a service that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
33. Enter details in the **Describe Alternative Tried/Considered** field. If an alternative service code has been entered in the adjacent field, leave the field blank.
34. Use the **Reason** drop-down list to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
35. Enter a brief explanation in the **Please explain why the least costly method of treatment is not being used** field.

The screenshot shows a form titled "Prescribing Physician Information". It contains five input fields, each with a circled number indicating a callout:

- Field 36: A large text area for the "Physician Prescription (255 characters accepted)".
- Field 37: A text box for the "Physician's License #".
- Field 38: A text box for the "Physician's Name".
- Field 39: Three text boxes for the "Physician's Phone" number, separated by parentheses and a hyphen.
- Field 40: A text box for the "Prescription Date".

36. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. This replaces the need for submitting this information as an attachment. *Always required.
37. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. This replaces the need for submitting this information as an attachment. *Always required.
38. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
39. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
40. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.

The screenshot shows a web form titled "Attachment A Service" with a "Continue" button. Below it is the "DME Attachment Form (Attachment B)". The form contains the following fields:

- 41** * Replacement? with radio buttons for "No" (selected) and "Yes".
- 43** Replacement Reason with three drop-down menus.
- 42** Ideal Weight with a text input field.
- 44** Unlisted Reason with three drop-down menus.

41. Click the circular **Replacement?** radio button to indicate whether the requested service is a replacement of a previous item received or authorized for the patient. This replaces the need for submitting this information as an attachment. *Always required.
42. Enter the patient's **Ideal Weight** in pounds.
43. If the circular Replacement radio button is selected as "Yes," use the **Replacement Reason** drop-down lists to select up to three reasons why the item previously received or authorized for the patient is being replaced.
44. If the service requested is for an unlisted code, use the **Unlisted Reason** drop-down lists to select up to three reasons why a listed code cannot be used in place of the unlisted code.

Specific Comments (150 characters accepted)

45

46 Serial #

47 Manufacturer

48 Model

49 Purchase Date
mmddyyyy

50 Purchased By

51 Warranty Expire Date
mmddyyyy

Attachment A Service

52 Continue

53 Another Service, Same Category

45. Enter **Specific Comments** explaining why the particular item, device, accessory is needed for the patient. For repairs or replacements, explain why an existing warranty does not cover the service.
46. Enter the **Serial #** of the product.
47. Enter the **Manufacturer** of the equipment.
48. Enter the **Model** or stock number identifying the equipment.
49. Enter the original **Purchase Date** (mmddyyyy) for repair or replacements. Otherwise, leave the field blank.
50. If Purchase Date is entered, use the **Purchased By** drop-down list to select the original purchaser of the equipment.
51. Enter the **Warranty Expire Date** (mmddyyyy) for equipment. If later than the request date, an explanation or medical justification of why the warranty does not cover repair or replacement must be entered in Miscellaneous TAR Information.
52. Click **Continue** to return to the TAR Services menu. See Module E for information on submitting the eTAR.
53. Click **Another Service, Same Category** to create another service line for the same service type.

Section 12. DME – Other

DME

eTAR Medical Tutorials

Please Enter DME Information

[Attachment A](#) [Attachment B](#)

Service Information

* **Service Code** (HCPCS Code) **Modifiers** (if applicable)

1 2

Service Description (40 characters accepted)

3

4 5 6 Quantity

1. Enter the **Service Code** to identify the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search. *Always required.
2. Enter up to four **Modifiers**. If unknown, click the Modifier link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave the field blank.
4. Use the **Side** drop-down list to select Right, Left or Bilateral.
5. Enter the **Total Units** requested. If requesting a rental, enter the number of rental months or days, depending on the service code entered. *Always required.
6. Enter the **Frequency** for the number of units that will be used per time period. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the equipment will be used twice per day, enter:

* Frequency

2 / Day

NOTE: The eTAR Medical Tutorials are accessible from the upper right corner on all eTAR Medical webpages.

7. Enter the **Quantity** for the number of units to be used per month. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If two units are anticipated to be used per month, enter:

8. Enter the **Ant. Length of Need** to indicate the appropriate period of the requested services. Enter the number of units in the first field and use the drop-down list to select the time period.

Example: If the patient will need the services for two months, enter:

9. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive.
10. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.
11. Enter the **Start of Care** (mmddyyyy) date the patient began, or will begin, receiving the service requested.
12. Use the **Admit From** drop-down list to select the level of care from where the patient was admitted.
13. Enter the **Discharge Date** (mmddyyyy). If Discharge has been selected, this field is required.

The screenshot shows a form with the following fields and callouts:

- 14**: Discharge (dropdown menu)
- 15**: *POS (dropdown menu)
- 16**: Rendering Provider # (text input)
- 17**: Pricing Override Request (dropdown menu)
- 18**: Price (text input)
- 19**: MSRP (text input)
- Discharge Date: mmdyyy (text input)
- *ICD-CM Type (dropdown menu)
- *ICD Code (Decimal Required) (text input)
- Diagnosis Description (text input)
- Date of Onset: mmdyyy (text input)
- Enter Miscellaneous TAR Information (500 characters accepted) (text area)

14. Use the **Discharge** drop-down list to select the level of care for the patient.
15. Use the **POS** drop-down list to select the location where the service is being rendered.
*Always required.
16. Enter a **Rendering Provider #** if rendering provider is different from the submitting provider. This will allow another provider to inquire on eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
17. Use the **Pricing Override Request** drop-down list to select an override code for unlisted items or prices.
18. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
19. Enter the **MSRP** (Manufacturer's Suggested Retail Price) or actual invoice price for the service being requested, up to seven digits.

The screenshot shows a web form with the following fields and labels:

- Discharge Date: Input field with placeholder 'mmddyyyy' and a dropdown arrow.
- Discharge: Input field with a dropdown arrow.
- * POS: Input field with a dropdown arrow.
- Pricing Override Request: Input field with a dropdown arrow.
- Price: Input field.
- MSRP: Input field.
- Rendering Provider #: Input field.
- *ICD-CM Type: Input field with a dropdown arrow, circled with '20'.
- * ICD Code (Decimal Required): Input field, circled with '21'.
- Diagnosis Description: Input field.
- Date of Onset: Input field with placeholder 'mmddyyyy', circled with '22'.
- Enter Miscellaneous TAR Information (500 characters accepted): Large text area with a scrollbar, circled with '23'.

- 20. Use the **ICD-CM Type** drop-down list to select the ICD code type.
- 21. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
- 22. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
- 23. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Attachment B Service

Patient assessment information for this Service (Attachment A)

P.O.T. Adherence

Feeding Method

In-Home Assistance/Care Giver Hrs/Day Days/Wk

Height ' "

Weight lbs. oz.

24. Use the **P.O.T Adherence** drop-down list to select the level of compliance the patient has to the Plan of Treatment.
25. Use the **Feeding Method** drop-down list to select the method of feeding for the patient.
26. Enter the amount of hours per day and days per week assistance is available to the patient in his or her home in the **In-Home Assistance/Care Giver** field.
27. Enter the patient's **Height** in feet and inches.
28. Enter the patient's **Weight** in pounds and ounces.

* Please list current functional limitation /physical condition codes

29

Please list previous functional limitation /physical condition codes

30

Please list current medical status codes relevant to requested service(s)

31

- 29. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes. This replaces the need for submitting this information as an attachment. *Always required.
- 30. Enter the previous functional limitation or physical condition relative to the requested services in the **Please list previous functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See Module J for more information on Code Search. See Appendix B for a list of functional limitation codes
- 31. Enter current medical status codes which describe the patient’s condition In the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes.

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
32	33		34
Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) -- include dates if applicable. (255 characters accepted)			
35			
If it is known that the patient has ever received the requested or similar service(s), please explain -- include dates. (255 characters accepted)			
36			
Please summarize the therapeutic goal to be met with the requested service(s). (255 characters accepted)			
37			

32. Use the **ICD-CM Type** drop-down list to select the ICD code type.
33. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.
NOTE: The **Diagnosis Description** field is no longer in use. Leave this field blank.
34. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
35. Enter a summary of the treatment and history of the patient in the **Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable** field.
36. Enter information regarding any similar services in the **If it is known that the patient has ever received the requested or similar service(s), please explain – include dates** field.
37. Enter a summary of the therapeutic goal to be met in the **Please summarize the therapeutic goal to be met with the requested service(s)** field.

Please list alternatives tried or considered and the reason why they are not feasible for this patient

Service Code	Describe Alternative Tried/Considered (30 characters accepted)
38 <input type="text"/>	39 <input type="text"/>
<input type="text"/>	Reason <input type="text"/> 40 <input type="text"/>
<input type="text"/>	Reason <input type="text"/>
<input type="text"/>	Reason <input type="text"/>
	Reason <input type="text"/>

Please explain why the least costly method of treatment is not being used. (255 characters accepted)

41

- 38. Enter the **Service Code** identifying a service that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code link to access Code Search. See Module J for more information on Code Search.
- 39. Enter details in the **Describe Alternative Tried/Considered** field. If an alternative service code has been entered in the adjacent field, leave the field blank.
- 40. Use the **Reason** drop-down list to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
- 41. Enter a brief explanation in the **Please explain why the least costly method of treatment is not being used** field.

Prescribing Physician Information

* Physician Prescription (255 characters accepted)

42

* Physician's License #

43

* Physician's Name

44

* Physician's Phone

45

* Prescription Date

46

42. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. This replaces the need for submitting this information as an attachment. *Always required.
43. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. This replaces the need for submitting this information as an attachment. *Always required.
44. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
45. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
46. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.

Attachment A Service

DME Attachment Form (Attachment B)

* Replacement?
 47 No Yes

Replacement Reason
 48 [Drop-down menu]

Unlisted Reason
 49 [Drop-down menu]

* Home Accessible?
 50 No Yes

* Safe Operation?
 51 No Yes

* Independent Operation?
 52 No Yes

Ideal Weight
 53 [Text input field]

47. Click the circular **Replacement?** radio button to indicate whether the requested service is a replacement of a previous item received or authorized for the patient. This replaces the need for submitting this information as an attachment. *Always required.
48. If the circular Replacement radio button is selected as “Yes,” use the **Replacement Reason** drop-down lists to select up to three reasons why the item previously received or authorized for the patient is being replaced.
49. If the service requested is for an unlisted code, use the **Unlisted Reason** drop-down lists to select up to three reasons why a listed code cannot be used in place of the unlisted code.
50. Click the circular **Home Accessible?** radio button to indicate if the patient’s home is accessible for the Equipment. This replaces the need for submitting this information as an attachment. *Always required.
51. Click the circular **Safe Operation?** radio button to indicate if the patient is able to operate the equipment requested safely. This replaces the need for submitting this information as an attachment. *Always required.
52. Click the circular **Independent Operation?** radio button to indicate if the patient is able to operate the equipment requested independently. This replaces the need for submitting this information as an attachment. *Always required.
53. Enter the patient’s **Ideal Weight** in pounds.

Specific Comments (150 characters accepted)

54

Equipment Already in Home Turning Information

Item	Usage (Hrs/Day)	Turning Schedule Every " _ " Hours	RSN
55	56	58	59

57

54. Enter **Specific Comments** explaining why the particular item, device, accessory is needed for the patient. For repairs or replacements, explain why an existing warranty does not cover the service.
55. Use the **Item** drop-down lists to select the equipment already present in the home relevant to the requested service.
56. Enter the average number of hours per day the patient uses the equipment in the **Usage** field.
57. Enter the number of hours scheduled between each turning In the **Turning Schedule Every " _ " Hours** field. This replaces the need for submitting this information as an attachment.
58. Use the **UTS** drop-down lists to select Unavailable Turning Surface (UTS).
59. If UTS is indicated, use the **RSN** drop-down lists to select the reason why the turning surface is unavailable for the patient.

The screenshot shows a form with the following fields and labels:

- Lab Date** (60): Input field with placeholder 'mmddyyyy'.
- Hemoglobin** (61): Input field.
- Hematocrit** (62): Input field.
- Albumin** (63): Input field.
- Trial Begin Date** (64): Input field with placeholder 'mmddyyyy'.
- Trial End Date** (65): Input field with placeholder 'mmddyyyy'.
- Results** (66): Drop-down menu.
- Serial #** (67): Input field.
- Manufacturer** (68): Input field.
- Model** (69): Input field.
- Purchase Date**: Input field with placeholder 'mmddyyyy'.
- Purchased By**: Input field with a drop-down arrow.
- Warranty Expire Date**: Input field with placeholder 'mmddyyyy'.

At the bottom of the form, there are three links: [Attachment A](#), [Attachment B](#), and [Services](#). Below these links are two buttons: **Continue** and **Another Service, Same Category**.

- 60. Enter the most recent **Lab Date** (mmddyyyy) when relevant lab test was performed. If the lab tests performed were not for hemoglobin, hematocrit, or albumin, enter the test and value in the specific comments fields or include on a free-form attachment.
- 61. Enter the most recent **Hemoglobin** lab score. Exclude the decimal point.
- 62. Enter the most recent **Hematocrit** lab score. Exclude the decimal point.
- 63. Enter the most recent **Albumin** lab score. Exclude the decimal point.
- 64. Enter the **Trial Begin Date** (mmddyyyy).
- 65. Enter the **Trial End Date** (mmddyyyy).
- 66. Use the **Results** drop-down list to select the results of the trial period.
- 67. Enter the **Serial #** of the product.
- 68. Enter the **Manufacturer** of the equipment.
- 69. Enter the **Model** or stock number identifying the equipment.

Lab Date	Hemoglobin	Hematocrit	Albumin	Trial Begin Date	Trial End Date
<input type="text" value="mmddyyyy"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="mmddyyyy"/>	<input type="text" value="mmddyyyy"/>
Results			Serial #		
<input type="text"/>			<input type="text"/>		
Manufacturer			Model		
<input type="text"/>			<input type="text"/>		
Purchase Date	Purchased By	Warranty Expire Date			
<input type="text" value="mmddyyyy"/>	<input type="text"/>	<input type="text" value="mmddyyyy"/>			
Attachment A Attachment B Services					
<input type="button" value="Continue"/>		<input type="button" value="Another Service, Same Category"/>			

70. Enter the **Purchase Date** (mmddyyyy) the equipment was originally purchased for repair or replacements only.
71. Use the **Purchased By** drop-down list to select the original purchaser of the equipment for repair or replacements only.
72. Enter the **Warranty Expire Date** (mmddyyyy) for the equipment. If later than the request date, an explanation or medical justification of why the warranty does not cover repair or replacement must be entered in Miscellaneous TAR Information.
73. Click **Continue** to return to the TAR Services menu. See Module E for information on submitting the eTAR.
74. Click **Another Service, Same Category** to create another service line for the same service type.