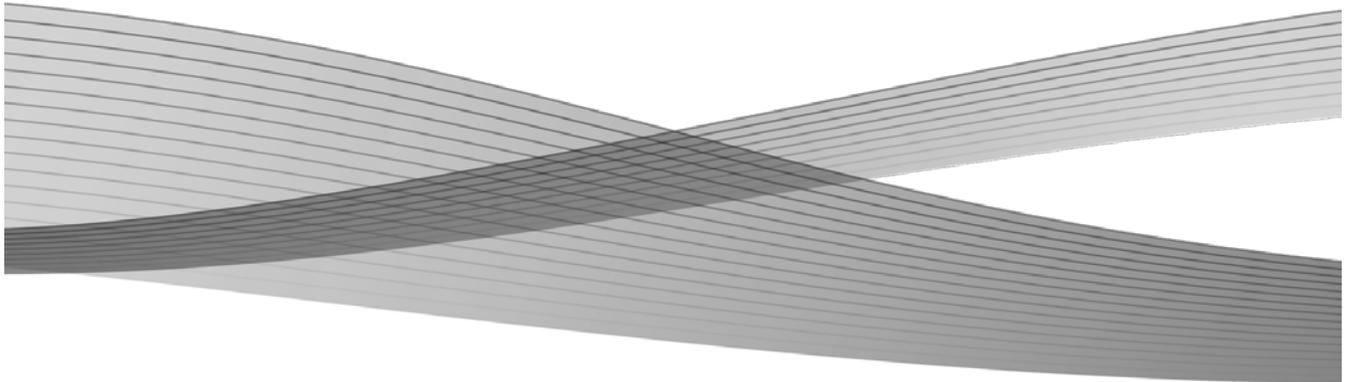




Treatment Authorization Request Medical User Guide 2016

All Other Provider Types





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!

Table of Contents

Module A: Introduction

Section 1: Training Policy.....	1
Section 2: eTAR Acronyms	2
Section 3: Purpose and Objectives	3

Module B: Accessing the TAR Menu

Section 1: Accessing the TAR Menu.....	1
Section 2: eTAR Medical Tutorials.....	3

Module C: Create a New eTAR

Section 1: Treatment Authorization Request Menu.....	1
Section 2: Provider Address Selection Option	3
Section 3: User Information.....	4
Section 4: Patient Information	6

Module D: TAR Services – All Other Provider Types

Section 1: Augmentive & Alternative Communication (AAC)	3
Section 2: Adult Day Health Care (ADHC)	11
Section 3: Opiate Detoxification	14
Section 4: EPSDT – Nutritional Services	16
Section 5: Home Health	23
Section 6: Hospice	26
Section 7: Non-Pharmacy Issued Drug.....	30
Section 8: Respiratory Therapy.....	32
Section 9: Speech/Occupational/Physical Therapy.....	39
Section 10: Transportation	46
Section 11: Contact Lens	54
Section 12: Low Vision Aids.....	64
Section 13: Other Eye Appliances.....	74

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 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. 06102015)
NCPDP	National Council for Prescription Drug Program
NPI	National Provider Identifier
NPES	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:

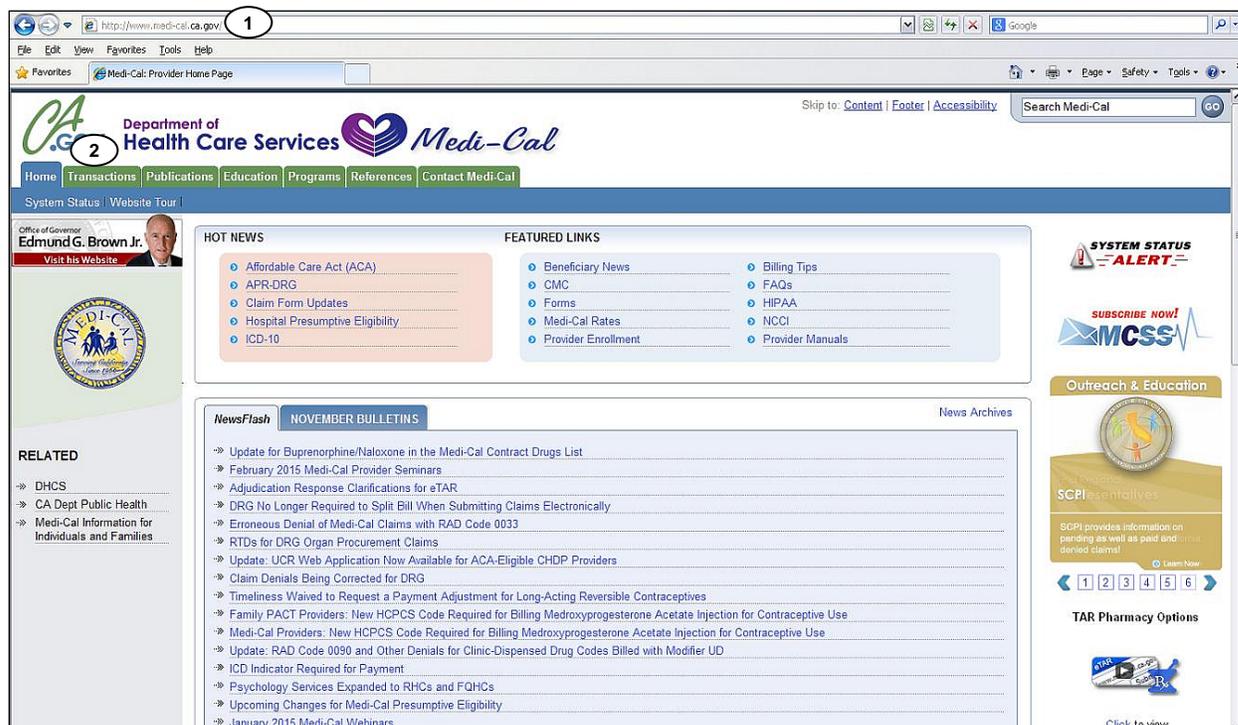
- ◆ Access the Medi-Cal website
- ◆ Log in to the Transaction Services menu
- ◆ Access the TAR menu.
- ◆ Create eTARs, update eTARs, and check TAR statuses online
- ◆ Submit attachments

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.
- ◆ Date must be completed with a two digit month, a two digit date, and a four digit year (mmddyyy) Example: June 10, 2015 is 06102015.
- ◆ Do not click Back from 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, there may be a pop-up blocker activated.
- ◆ 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:

Please enter your Password:

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.

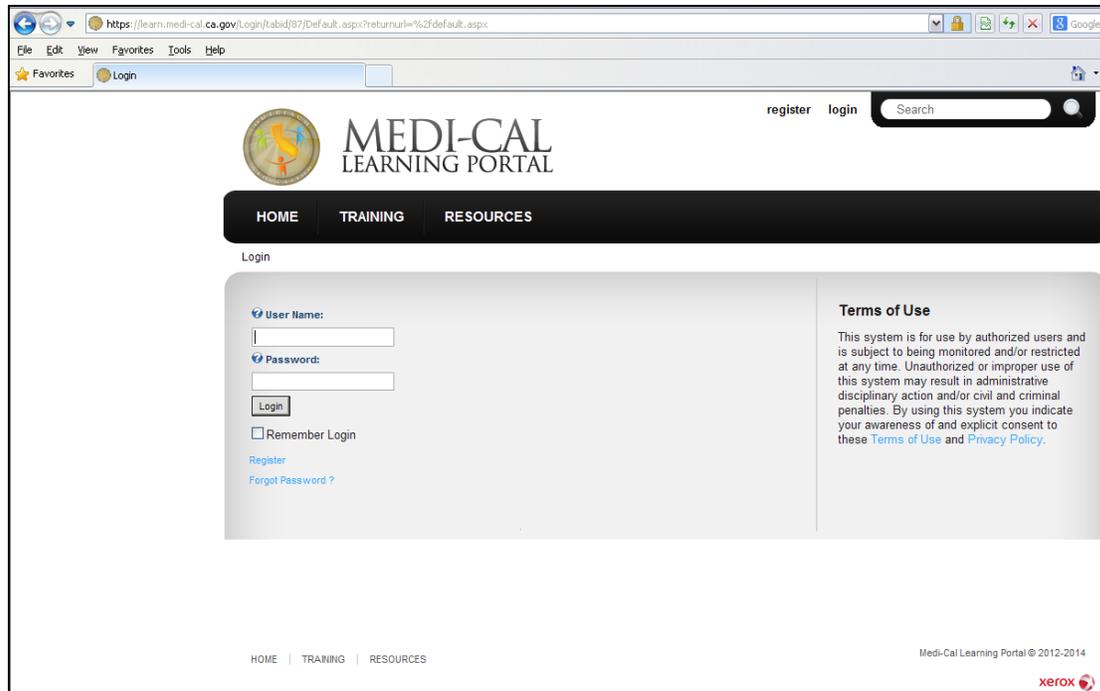
NOTE: If unable to log in, call the Telephone Support Center at 1-800-541-5555.

Section 2. eTAR Medical Tutorials

The screenshot shows the Medi-Cal website interface. At the top, there is a navigation bar with links: Home, Transactions, Publications, Education, Programs, References, and Contact Medi-Cal. Below this is a secondary bar with links: System Status, Exit, Services Available, and Enrollment Requirements. The main content area features the Medi-Cal logo on the left and a 'Transaction Services' section on the right. The 'Transaction Services' section includes a login status bar: 'You are logged in as: 0099097830'. Below the login bar are three tabs: 'Elig', 'Claims', and 'eTAR'. The 'eTAR' tab is active, displaying a list of services: Single Subscriber, Multiple Subscribers, Automated Provider Services (PTN), Batch Internet Eligibility, Lab Services Reservation System (LSRS), and Medical Services Reservations (Medi-Services), and SOC (Spend Down) Transactions. On the left side, under the 'TRANSACTIONS' heading, there is a list of categories: Eligibility, Claims, and eTAR. Under the 'eTAR' category, there is a list of options: Inquire Only, Inquire Tutorial, Medical Services, Medical Tutorials (circled with a '1'), and Pharmacy.

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 menu with "HOME", "TRAINING", and "RESOURCES" options. The main content area is titled "Login" and contains a form with the following elements:

- User Name:** A text input field.
- Password:** A text input field.
- Login:** A button.
- Remember Login:** A checkbox.
- Register:** A blue link.
- Forgot Password ?** A blue link.

To the right of the login form is a "Terms of Use" section with the following text:

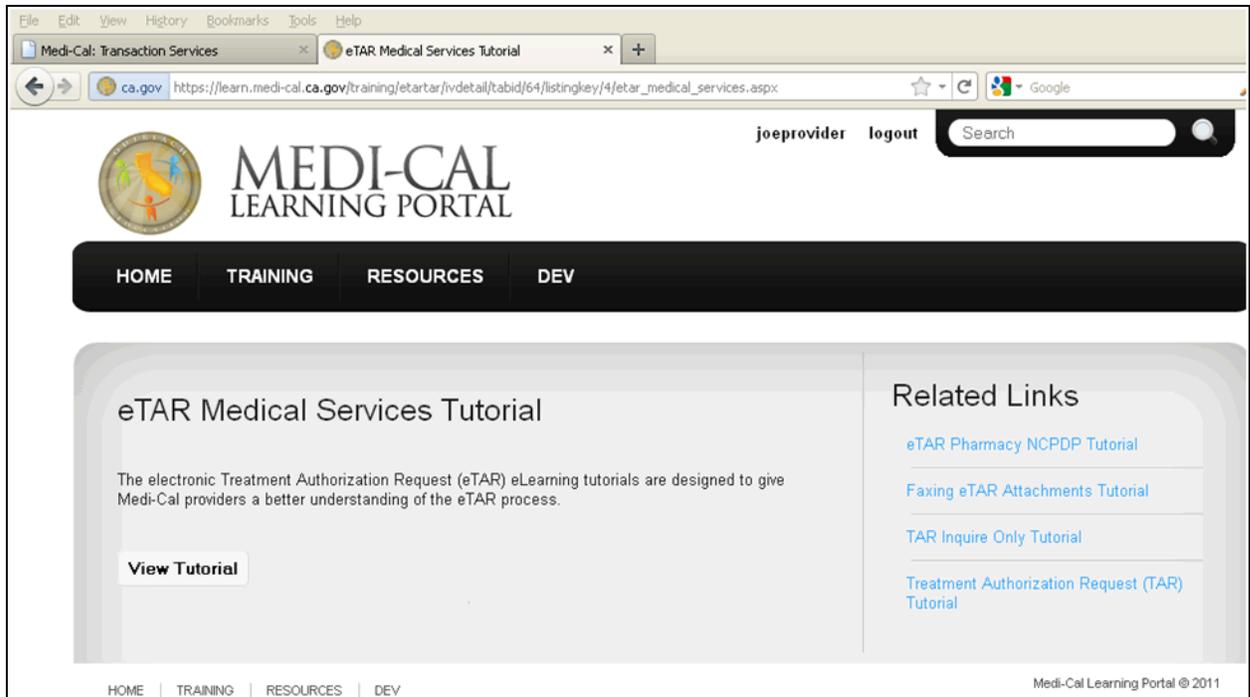
This system is for use by authorized users and is subject to being monitored and/or restricted at any time. Unauthorized or improper use of this system may result in administrative disciplinary action and/or civil and criminal penalties. By using this system you indicate your awareness of and explicit consent to these [Terms of Use](#) and [Privacy Policy](#).

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.

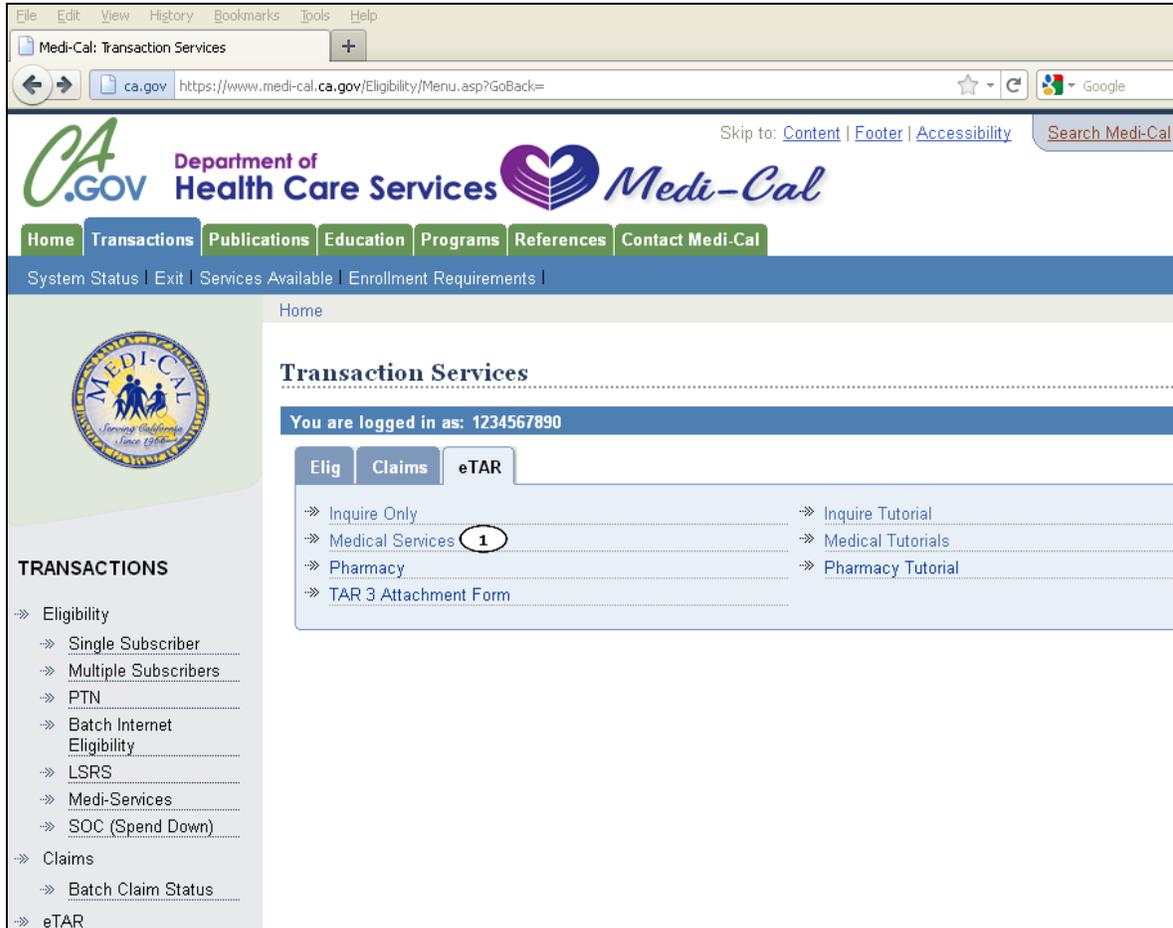
When done with the tutorial, close the session by clicking **X** in the window of this session.

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 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 page content is titled "TAR Menu" and includes a "TAR Menu" section with a circled "2" next to "Create a New TAR". Below this, there is a "TRANSACTIONS" section.

TAR

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

TRANSACTIONS

TAR Menu

[eTAR Medical Tutorials](#)

Welcome to the Treatment Authorization Request (TAR) menu. Please choose from one of the following options:

- 2** -> [Create a New TAR](#)
- > [Update an existing TAR](#)
- > [Upload TAR Attachments](#)
- > [Inquire on a TAR](#)
- > [View TAR Responses](#)
- > [Code Search](#)

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

2 Medicare Cert?

3 Provider Name
COMMUNITY MEDICAL CLINIC

Phone #
(916) 636-1200

Street/Mailing Address
820 Stillwater Road

City State Zip Code
W. Sacramento CA 95670

5 Contact Name

7 Contact Phone #
() -

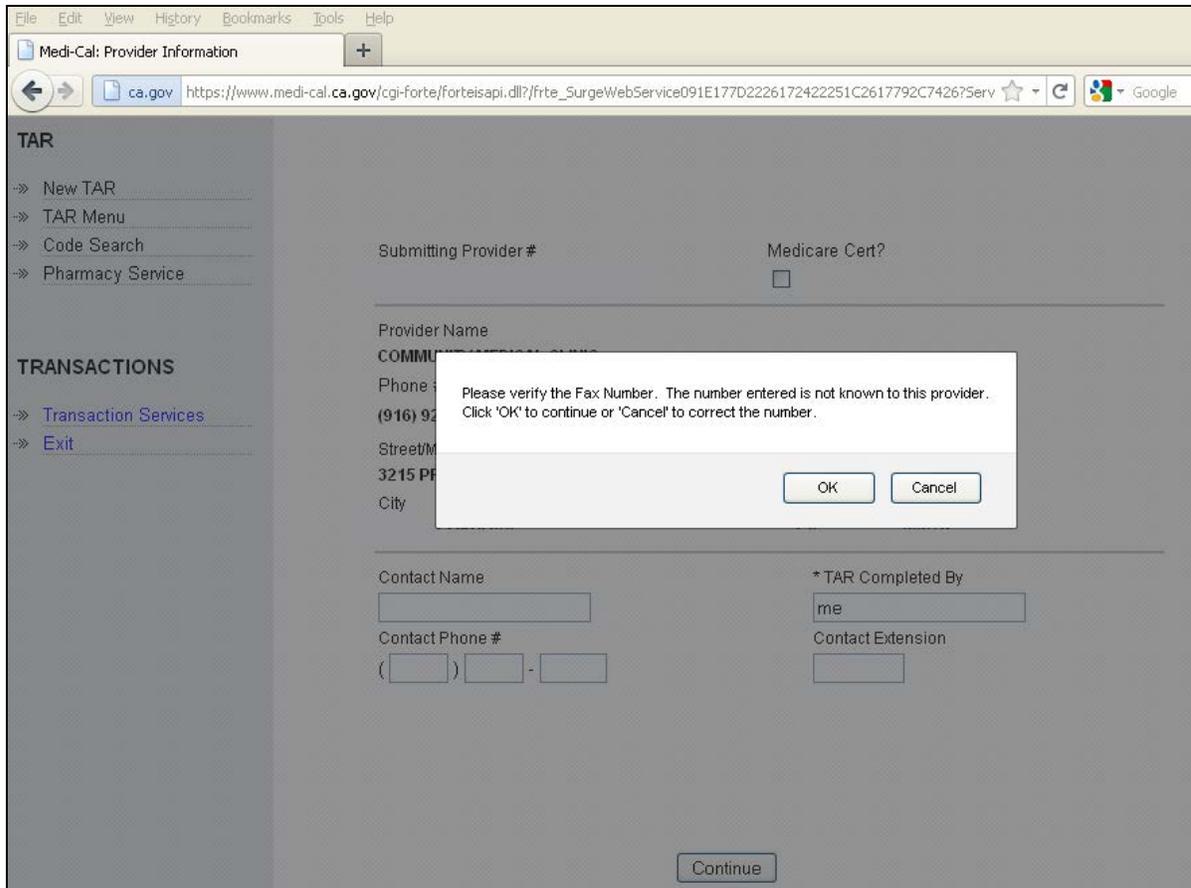
4 Fax #
() -

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 content 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.
- 3. Special Handling: A drop-down menu.

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 Female <input type="radio"/> <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" with the following fields and a button:

- 18: Name (text input field)
- 19: Street/Mailing Address (text input field)
- 20: City (text input field)
- 21: State (dropdown menu)
- 22: Zip Code (text input field)
- 23: Continue (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 – All Other Provider Types

Service Category Selection

Add Service - Category Unknown

* Service Code Search

1

2

Find Service Category(s)

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** 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.

TAR Services – All Other Provider Types

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
E2599	SGD ACCESSORY NOC	P	3 AAC	SMA/HCPSCS	TAR Required
E2599	SGD ACCESSORY NOC	P	DME - Other	SMA/HCPSCS	TAR Required

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

[Return to TAR Services Menu](#)

3. Select the **Service Category** that applies to the services being submitted.

NOTE: See the eTAR Medical User Guide Part 2 for Modules E–J and Appendices A and B.

Section 1. Augmentive & Alternative Communication (AAC)

[eTAR Medical Tutorials](#)

Please Enter AAC Information

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

Service Information

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

Service Description (40 characters accepted)

* **Total Units** **Ant. Length of Need** **From Date** **Thru Date**

/

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it populates automatically. If unknown, click the Service Codes 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 Modifiers 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 **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 two services per month, enter:

Ant. Length of Need

/

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

TAR Services – All Other Provider Types

* Total Units	Ant. Length of Need	From Date	Thru Date
<input type="text"/>	<input type="text"/> / <input type="text"/> <input type="button" value="v"/>	<input type="text" value="mmddyyyy"/>	<input type="text" value="mmddyyyy"/>
Place of Service			
<input type="text" value=""/>	<input type="button" value="v"/>		
Rendering Provider #			
<input type="text"/>			
Pricing Override Request		Price	
<input type="text" value=""/>	<input type="button" value="v"/>	<input type="text"/>	

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

The screenshot shows a web form with the following fields:

- * ICD-CM Type**: A dropdown menu with a downward arrow, circled with the number 12.
- * ICD Code (Decimal Required)**: A text input field, circled with the number 13.
- Diagnosis Description**: A text input field.
- Enter Miscellaneous TAR Information (500 characters accepted)**: A large text area with a vertical scrollbar, circled with the number 14.

12. Use the **ICD-CM Type** drop-down list to select the ICD code type.
 13. Enter the **ICD Code** indicating the primary diagnosis relative to the requested service, including the decimal point. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search. *Always required.
- NOTE:** The **Diagnosis Description** field is no longer in use. Leave this field blank.
14. **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)

* P.O.T. Adherence

15 ▼

* Please list current functional limitation /physical condition codes

16

* Please list previous functional limitation /physical condition codes

17

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

18

15. 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.
16. 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.
17. 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. This replaces the need for submitting this information as an attachment. *Always required.
18. Enter current medical status codes that 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 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
19 <input type="text"/>	20 <input type="text"/>	<input type="text"/>	21 <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)			
22 <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)			
23 <input type="text"/>			
Please summarize the therapeutic goal to be met with the requested service(s). (255 characters accepted)			
24 <input type="text"/>			

19. Use the **ICD-CM Type** drop-down to select the ICD code type for each secondary ICD code.
 20. Enter secondary **ICD Code**, including the decimal point, indicating the diagnosis relative 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.
21. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
 22. 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.
 23. 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.
 24. 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.

TAR Services – All Other Provider Types

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)
25	26
Reason	27
Reason	
Reason	
Reason	

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

28

25. 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.
26. 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.
27. 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.
28. 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)

29

* Physician's License # * Physician's Name

30 31

* Physician's Phone * Prescription Date

32 33

29. 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
30. 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.
31. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
32. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
33. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.

DME Attachment Form (Attachment B)

* Replacement? 34
 No Yes

Replacement Reason 35
 [Dropdown menu]
 [Dropdown menu]
 [Dropdown menu]

Why are you requesting an unlisted procedure code? 36
 [Dropdown menu]
 [Dropdown menu]
 [Dropdown menu]

Specific Comments (150 characters accepted) 37
 [Text area]

Attachment A Attachment B Service

38 Continue 39 Another Service, Same Category

34. 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.
35. 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.
36. If the service requested is under an unlisted code, use the **Why are you requesting an unlisted procedure code?** drop-down lists to select up to three reasons why a listed code cannot be used in place of the unlisted code.
37. 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.
38. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.
39. Click **Another Service, Same Category** to create another service line for the same service type.

Section 2. Adult Day Health Care (ADHC)

Other Services

[eTAR Medical Tutorials](#)

Please Enter ADHC Information

Service Information

* Service Code (HCPCS or FQHC Per Visit Code) Modifiers (if applicable)

1 2

* Total Units * Schedule * Frequency

3 4 /

NOTE:

- ◆ ADHC is now known as Community-Based Adult Services (CBAS). Because the eTAR system still uses ADHC, this user guide refers to ADHC, not CBAS.
 - ◆ ADHC providers have to submit TARs with one calendar month per line.
Example: Line 1 = May 15 – May 31, Line 2 = June 1 – June 30
 - ◆ Providers may claim up to 4 carryover (unused) days per month, except in the sixth month of service of the TAR to the first month of service on a new TAR.
 - ◆ Providers may only submit up to six lines of service, even if the first service starts mid-calendar month.
 - ◆ Reauthorizations will be accepted for ADHC TARs as long as the extension is within one calendar month already on the TAR.
 - ◆ If the TAR has less than six months of service submitted and the provider needs to extend the services beyond one service line, they may extend the service using Add Service (Module F) for up to a total of six months (six service lines).
 - ◆ If an extension is needed past six months, a new TAR is required.
1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it populates automatically. 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 Modifiers link to access Code Search. See Module J for more information on Code Search.
 3. Enter the **Total Units** requested. *Always required.
 4. Use the **Schedule** 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. *Always required.

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

TAR Services – All Other Provider Types

5. Enter the **Frequency** 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.
*Always required.

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

6. Enter the **From Date** (mmddyyyy) for the requested start of service date. *Always required.
7. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date *Always required.
8. Enter the date the patient was or will be admitted in the **Admit Date** field (mmddyyyy).
*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. Use the **Admit From** drop-down list to select the level of care from where the patient was admitted. *Always required.

The screenshot displays a web form for entering TAR service information. It features the following elements:

- * ICD-CM Type**: A drop-down menu labeled 12.
- * ICD Code (Decimal Required)**: A text input field labeled 13.
- Diagnosis Description**: A text input field.
- Date of Onset**: A text input field labeled 14 with a placeholder 'mmddyyyy'.
- Enter Miscellaneous TAR Information (500 characters accepted)**: A large text area labeled 15.
- Buttons**: Two buttons at the bottom, labeled 16 ('Continue') and 17 ('Another Service, Same Category').

12. Use the **ICD-CM Type** drop-down list to select the ICD code type.
 13. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD code link to access Code Search. See Module J for more information on Code Search. *Always required.
- NOTE:** The **Diagnosis Description** field is no longer in use. Leave this field blank.
14. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
 15. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.
 16. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.
 17. Click **Another Service, Same Category** to create another service line for the same service type.

Section 3. Opiate Detoxification

[eTAR Medical Tutorials](#)

Other Services

Please Enter Detox Information

Service Information

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

1 2

* Total Units * From Date * Thru Date

3 4 5

* ICD Code (Decimal) Date of Onset

* ICD-CM Type Required Diagnosis Description mmddyyyy

Enter Miscellaneous TAR Information (500 characters accepted)

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it populates automatically. 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 Modifiers link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Total Units** requested. *Always required.
4. Enter the **From Date** (mmddyyyy) for the requested start of service date. *Always required.
5. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. *Always required.

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

Other Services

[eTAR Medical Tutorials](#)

Please Enter Detox Information

Service Information

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

* Total Units * From Date * Thru Date

mmddyyyy mmddyyyy

* ICD Code (Decimal)

* ICD-CM Type Required Diagnosis Description Date of Onset

6 **7** **8**

Enter Miscellaneous TAR Information (500 characters accepted)

9

10 **11**

6. Use the **ICD-CM Type** drop-down list to select the ICD code type.
 7. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD code link to access Code Search. See Module J for more information on Code Search. *Always required.
- NOTE:** The **Diagnosis Description** field is no longer in use. Leave this field blank.
8. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
 9. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.
 10. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.
 11. Click **Another Service, Same Category** to create another service line for the same service type.

Section 4. EPSDT – Nutritional Services

Other Services

[eTAR Medical Tutorials](#)

Please Enter EPSDT Nutritional Information

[Attachment A](#)

Service Information

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

1 2

Service Description (40 characters accepted)

3

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

4 5 / /

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it populates automatically. 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 Modifiers 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 this field blank.
4. Enter the **Total Units** requested. *Always required.
5. Enter the **Quantity** of units to be used per week or month. Enter the number of units in the first field and use the drop-down list to select the time period. *Always required.

Example: If 30 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 Web pages.

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

- * Total Units: []
- * Quantity: [] / [] [v]
- * Ant. Length of Need: (6) [] / [] [v]
- From Date: (7) [mmddyyyy]
- Through Date: (8) [mmddyyyy]
- * POS: (9) [] [v]
- Rendering Provider #: (10) []
- Price: (11) []
- Price Override: (12) [] [v]

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. *Always required.

Example: If the patient will need two services per month, enter:

* Ant. Length of Need
2 / Month [v]

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 **Through Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.
9. Use the **POS** drop-down list to select the location where the service is being rendered. *Always required.
10. Enter a **Rendering Provider #** if the rendering provider is different from the submitting provider. This allows another provider to inquire on TAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
11. Enter the **Price** requested, including the decimal point, for unlisted items or prices, up to seven digits. If Pricing Override Request is selected, this field is required.
12. Use the **Pricing Override** drop-down list to select an override code for unlisted items or prices.

TAR Services – All Other Provider Types

The screenshot shows a web form with the following elements:

- * ICD-CM Type Required:** A dropdown menu labeled 13.
- * ICD Code (Decimal):** A text input field labeled 14.
- Diagnosis Description:** A text input field.
- Date of Onset:** A text input field labeled 15 with the format 'mmddyyyy'.
- Enter Miscellaneous TAR Information (500 characters accepted):** A large text area labeled 16.
- Buttons:** 'Continue' and 'Another Service, Same Category'.

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

Patient assessment information for this Service (Attachment A)

P.O.T. Adherence Feeding Method

17 18

* Height * Weight

19 , " 20 lbs. oz.

Please list current functional limitation /physical condition codes

21

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

22

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

17. Use the **P.O.T. Adherence** drop-down list to select the level of compliance the patient has to the Plan of Treatment.
18. Use the **Feeding Method** drop-down list to select the method by which the patient is fed.
19. Enter the patient's **Height** in feet and inches. This replaces the need for submitting this information as an attachment. *Always Required
20. Enter the patient's **Weight** in pounds and ounces. This replaces the need for submitting this information as an attachment. *Always Required
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 current medical status codes that 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 link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes.
23. Use the **ICD-CM Type** drop-down list to select the ICD code type.
24. Enter secondary **ICD Code**, including the decimal point, indicating the diagnosis relative to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search.

TAR Services – All Other Provider Types

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
<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"/>	<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

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

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

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

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

<p>Service Code</p> <p>29</p>	<p>Describe Alternative Tried/Considered (30 characters accepted)</p> <p>30</p>
<p>Reason</p> <p>31</p>	<p>▼</p>

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.

Prescribing Physician Information

* Physician Prescription (255 characters accepted)
 32

* Physician's License #
 33

* Physician's Name
 34

* Physician's Phone
 35

* Prescription Date
 36

Attachment A Service
 37 Continue 38 Another Service, Same Category

32. 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.
33. 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.
34. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
35. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
36. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.
37. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.
38. Click **Another Service, Same Category** to create another service line for the same service type.

Section 5. Home Health

[eTAR Medical Tutorials](#)

Please Enter Home Health Information

Service Information

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

1 2

* **Total Units** * **Frequency** * **From Date** * **Thru Date**

3 4 / 5 mmddyyyy 6 mmddyyyy

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it populates automatically. 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 Modifiers link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Total Units** requested. *Always required.
4. Enter the **Frequency** 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.
*Always required.

Example: If the patient will need three visits per week, enter:

* Frequency

3 / Week

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.

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

TAR Services – All Other Provider Types

Discharge Date	* Admit Date/Start of Care		
7 mmddyyyy	8 mmddyyyy		
Discharge			
9			
Admit From			
10			
POS			
11			
*ICD-CM Type	* ICD Code (Decimal Required)	Diagnosis Description	* Date of Onset
12	13		14 mmddyyyy

7. Enter the **Discharge Date** (mmddyyyy). If Discharge has been selected, this field is required.
 8. Enter the date the patient was or will be admitted in the **Admit Date/Start of Care** field (mmddyyyy). *Always required.
 9. Use the **Discharge** drop-down list to select the level of care for the patient.
 10. Use the **Admit From** drop-down list to select the level of care from where the patient was admitted.
 11. Use the **POS** drop-down list to select the location where the service is being rendered.
 12. Use the **ICD-CM Type** drop-down list to select the ICD code type.
 13. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search. *Always required.
- NOTE:** The **Diagnosis Description** field is no longer in use. Leave this field blank.
14. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field. *Always required.

The screenshot shows a web form for entering TAR service information. At the top, there are three input fields: a dropdown menu for '* ICD-CM Type Required', a text box for '* ICD Code (Decimal)', and a text box for 'Diagnosis Description'. To the right is a date input field labeled 'Date of Onset' with the format 'mmddyyyy'. Below these is a large text area labeled 'Enter Miscellaneous TAR Information (500 characters accepted)'. A callout '15' points to the top-left corner of this text area. At the bottom of the text area are two buttons: 'Continue' (callout '16') and 'Another Service, Same Category' (callout '17').

- 15. Enter **Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.
- 16. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.
- 17. Click **Another Service, Same Category** to create another service line for the same service type.

Section 6. Hospice

Other Services

[eTAR Medical Tutorials](#)

Please Enter Hospice Information

Attachment A

Service Information

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

1 2

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

3 4 5 6 7

Discharge

8

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it populates automatically. 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 Modifiers link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Total Units** requested. *Always required.
4. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive.
5. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.
6. Enter the **Start of Care** (mmddyyyy) date the patient was admitted to hospice. *Always required.
7. Enter the **Discharge Date** (mmddyyyy). If Discharge has been selected, this field is required
8. Use the **Discharge** drop-down list to select the level of care for the patient.

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

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

- Admit From**: A dropdown menu with the number 9 circled next to it.
- * POS**: A dropdown menu with the number 10 circled next to it.
- Rendering Provider #**: A text input field with the number 11 circled next to it.
- * ICD-CM Type**: A dropdown menu with the number 12 circled next to it.
- * ICD Code (Decimal Required)**: A text input field with the number 13 circled next to it.
- Diagnosis Description**: A text input field.
- Date of Onset**: A text input field with the format 'mmddyyyy' and the number 14 circled next to it.
- Enter Miscellaneous TAR Information (500 characters accepted)**: A large text area with the number 15 circled next to it.

9. Use the **Admit From** drop-down list to select the level of care from where the patient was admitted.
 10. Use the **POS** drop-down list to select the location where the service is being rendered.
*Always required.
 11. Enter a **Rendering Provider #** if rendering provider is different from the submitting provider. This allows another provider to inquire on TAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
 12. Use the **ICD-CM Type** drop-down list to select the ICD code type.
 13. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search. *Always required.
- NOTE:** The **Diagnosis Description** field is no longer in use. Leave this field blank.
14. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
 15. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

TAR Services – All Other Provider Types

Feeding Method

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	19		20

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

Attachment A Service

Continue Another Service, Same Category

16. Use the **Feeding Method** drop-down list to select the method by which the patient is fed.
 17. Enter current medical status codes that 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](#) link to access Code Search. This replaces the need for submitting this information as an attachment. *Always required.
 18. Use the **ICD-CM Type** drop-down list to select the ICD code type.
 19. Enter secondary **ICD Code**, including the decimal point, indicating the diagnosis relative 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. This replaces the need for submitting this information as an attachment. *Always Required.

Feeding Method

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

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	* Date Of Onset
<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"/>	<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)

21

Attachment A Service

22 23

21. 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. This replaces the need for submitting this information as an attachment. *Always Required.
22. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.
23. Click **Another Service, Same Category** to create another service line for the same service type.

Section 7. Non-Pharmacy Issued Drug

[eTAR Medical Tutorials](#)

Please Enter Non-Pharmacy Issued Drug Information

Service Information

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

1 2

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

3 4 / 5 /

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it populates automatically. If unknown, click the Service Codes 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 Modifiers link to access Code Search. See Module J for more information on Code Search.
3. Enter the **Total Units** requested. *Always required.
4. Enter the **Frequency** 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. *Always required.

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

* Frequency

3 / Week

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 two services per month, enter:

Ant. Length of Need

2 / Month

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

The screenshot shows a web form with the following elements:

- From Date (6):** A text input field with the placeholder 'mmddyyyy'.
- Thru Date (7):** A text input field with the placeholder 'mmddyyyy'.
- Rendering Provider # (8):** A text input field.
- POS (9):** A drop-down menu.
- * ICD-CM Type (10):** A drop-down menu.
- * ICD Code (Decimal Required) (11):** A text input field.
- Diagnosis Description:** A text input field.
- Enter Miscellaneous TAR Information (500 characters accepted) (12):** A large text area with a scroll bar.
- Continue (13):** A blue button.
- Another Service, Same Category (14):** A grey button.

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 a **Rendering Provider #** if the rendering provider is different from the submitting provider. This allows another provider to inquire on TAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
9. Use the **POS** drop-down list to select the location where the service is being rendered.
10. Use the **ICD-CM Type** drop-down list to select the ICD code type.
11. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search. *Always required.

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

12. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.
13. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.
14. Click **Another Service, Same Category** to create another service line for the same service type.

Section 8. Respiratory Therapy

Other Services

[eTAR Medical Tutorials](#)

Please Enter Respiratory Therapy Information

Attachment A

Service Information

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

1 2

Service Description (40 characters accepted)

3

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

4 5 / /

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it populates automatically. If unknown, click the Service Codes 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 Modifiers 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 this field blank.
4. Enter the **Total Units** requested. *Always required.
5. Enter the **Quantity** of units to be used per week or month. 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 are anticipated to be used per month, enter:

* Quantity

2 / Month

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

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

- * Total Units**: An empty text input field.
- * Quantity**: A text input field followed by a slash and a dropdown menu.
- * Frequency**: A text input field followed by a slash and a dropdown menu. Callout 6 points to the first input field.
- * Schedule**: A dropdown menu. Callout 7 points to the dropdown.
- Ant. Length of Need**: A text input field followed by a slash and a dropdown menu. Callout 8 points to the first input field.
- * From Date**: A text input field with the placeholder 'mmddyyyy'. Callout 9 points to the field.
- * Thru Date**: A text input field with the placeholder 'mmddyyyy'. Callout 10 points to the field.
- * Start of Care**: A text input field with the placeholder 'mmddyyyy'. Callout 11 points to the field.
- Discharge Date**: A text input field with the placeholder 'mmddyyyy'. Callout 12 points to the field.

6. Enter the **Frequency** 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. *Always required.

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

The close-up shows the *** Frequency** field with the number '3' in the text input and 'Day' selected in the dropdown menu.

7. Use the **Schedule** drop-down list to select the details for the requested service. If the schedule selected is Other, enter the schedule in the Enter Miscellaneous TAR Information field. *Always required.
8. Enter the **Ant. Length of Need** to indicate the 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 two services per month, enter:

The close-up shows the **Ant. Length of Need** field with the number '2' in the text input and 'Month' selected in the dropdown menu.

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

TAR Services – All Other Provider Types

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

- Discharge** (13): A drop-down menu.
- * Place of Service** (14): A drop-down menu.
- Rendering Provider #** (15): A text input field.
- *ICD-CM Type** (16): A drop-down menu.
- * ICD Code (Decimal Required)** (17): A text input field.
- Diagnosis Description**: A text input field.
- Date of Onset** (18): A text input field with the format "mmddyyyy".
- Enter Miscellaneous TAR Information (500 characters accepted)** (19): A large text area with a vertical scrollbar.

13. Use the **Discharge** drop-down list to select the level of care for the patient.
 14. Use the **Place of Service** drop-down list to select the location where the service is being rendered. *Always required.
 15. Enter a **Rendering Provider #** if the rendering provider is different from the submitting provider. This allows another provider to inquire on TAR service information. If the submitting and rendering provider numbers are the same, leave the field blank
 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 relative to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search. *Always required.
- 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.

Service

Patient assessment information for this Service (Attachment A)

P.O.T. Adherence
 20 ▾

Height
 21 ' "

Weight
 22 lbs. oz.

* Please list current **functional limitation/physical condition codes**
 23

* Please list previous **functional limitation/physical condition codes**
 24

* Please list current **medical status codes relevant to requested service(s)**
 25

20. Use the **P.O.T. Adherence** drop-down list to select the level of compliance the patient has to the Plan of Treatment.
21. Enter the patient's **Height** in feet and inches.
22. Enter the patient's **Weight** in pounds and ounces.
23. 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.
24. 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. This replaces the need for submitting this information as an attachment. *Always required.
25. Enter current medical status codes that 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 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.

TAR Services – All Other Provider Types

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
26	27		28
Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) -- include dates if applicable. (255 characters accepted)			
29			
* Please summarize the therapeutic goal to be met with the requested service(s). (255 characters accepted)			
30			

26. Use the **ICD-CM Type** drop-down list to select the ICD code type.
 27. Enter secondary **ICD Code**, including the decimal point, indicating the diagnosis relative 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 a summary of the therapeutic goal to be met in the **Please summarize the therapeutic goal to be met with the requested service(s)** This replaces the need for submitting this information as an attachment. *Always required.

* 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 <input type="text"/>	32 <input type="text"/>
	* Reason 33 <input type="text"/>
<input type="text"/>	<input type="text"/>
	Reason <input type="text"/>
<input type="text"/>	<input type="text"/>
	Reason <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 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. This replaces the need for submitting this information as an attachment. *Always required.
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. This replaces the need for submitting this information as an attachment. *Always required.
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. This replaces the need for submitting this information as an attachment. *Always required.
34. Enter a brief explanation in the **Please explain why the least costly method of treatment is not being used** field. This replaces the need for submitting this information as an attachment. *Always required.

Prescribing Physician Information

* Physician Prescription (255 characters accepted)

35

* Physician's License #

36

* Physician's Name

37

* Physician's Phone

38

* Prescription Date

39

Attachment A Service

40 Continue

41 Another Service, Same Category

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.
40. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.
41. Click **Another Service, Same Category** to create another service line for the same service type.

Section 9. Speech/Occupational/Physical Therapy

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it populates automatically. If unknown, click the Service Codes 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 Modifiers 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 this field blank.
4. Use the **Side** drop-down list to select Right, Left or Bilateral.
5. Enter the **Total Units** requested. *Always required.
6. Enter the **Frequency** 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. *Always required.

Example: If the patient will need one visit per week, enter:

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

TAR Services – All Other Provider Types

Side <input type="text"/>	* Total Units <input type="text"/>	* Frequency 1 / Week	* Ant. Length of Need 7 / <input type="text"/>
From Date 8 mmddyyyy	Thru Date 9 mmddyyyy	Start of Care 10 mmddyyyy	Discharge Date 11 mmddyyyy
Discharge 12 <input type="text"/>			
Rendering Provider # 13 <input type="text"/>			
* POS 14 <input type="text"/>			

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. *Always required.

Example: If the patient will need two services per month, 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.
11. Enter the **Discharge Date** (mmddyyyy). If Discharge has been selected, this field is required.
12. Use the **Discharge** drop-down list to select the level of care for the patient.
13. Enter a **Rendering Provider #** if the rendering provider is different from the submitting provider. This allows another provider to inquire on TAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
14. Use the **POS** drop-down list to select the location where the service is being rendered. *Always required.

The screenshot shows a web form with the following elements:

- * ICD-CM Type** (15): A drop-down menu.
- * ICD Code (Decimal Required)** (16): A text input field.
- Diagnosis Description**: A text input field.
- Date of Onset** (17): A text input field with the format `mmddyyyy`.
- Enter Miscellaneous TAR Information (500 characters accepted)** (18): A large text area with a vertical scrollbar.
- Continue**: A blue button.
- Another Service, Same Category**: A grey button.

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 relative to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search. *Always required.
- 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.

P.O.T. Adherence		Feeding Method	
19	<input type="text"/>	20	<input type="text"/>
* In-Home Assistance/Care Giver		Height	Weight
21	<input type="text"/> Hrs/Day <input type="text"/> Days/Wk	22	<input type="text"/> ' <input type="text"/> "
		23	<input type="text"/> lbs. <input type="text"/> oz.
* Please list current functional limitation/physical condition codes			
24	<input type="text"/>	<input type="text"/>	<input type="text"/>
Please list previous functional limitation/physical condition codes			
25	<input type="text"/>	<input type="text"/>	<input type="text"/>
Please list current medical status codes relevant to requested service(s)			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 by which the patient is fed.
21. Enter the number 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. These fields do not accept a value of zero. If no in-home caregiver assistance is available, either leave the field blank or enter 1 in each field and explain in the Miscellaneous TAR Information field. This replaces the need for submitting this information as an attachment. *Always required.
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. This replaces the need for submitting this information as an attachment. *Always required.
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.

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

26

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

26. Enter current medical status codes that 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 link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes.

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

28. Enter secondary **ICD Code**, including the decimal point, indicating the diagnosis relative 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. This replaces the need for submitting this information as an attachment. *Always required.

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. This replaces the need for submitting this information as an attachment. *Always required.

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

32

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)	* Reason
33	34	35

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. This replaces the need for submitting this information as an attachment. *Always required.
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. This replaces the need for submitting this information as an attachment. *Always required.
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. This replaces the need for submitting this information as an attachment. *Always required.
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. This replaces the need for submitting this information as an attachment. *Always required.

Prescribing Physician Information

* Physician Prescription (255 characters accepted)

36

* Physician's License #

37

* Physician's Name

38

* Physician's Phone

39

* Prescription Date

40

Attachment A Service

41 42

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.
41. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.
42. Click **Another Service, Same Category** to create another service line for the same service type.

Section 10. Transportation

Other Services

eTAR Medical Tutorials

Please Enter Transportation Information

Attachment A

Service Information

Rendering Provider #

* From Date * Thru Date * Frequency

* Schedule

1. Enter a **Rendering Provider #** if the rendering provider is different from the submitting provider. This allows another provider to inquire on TAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
2. Enter the **From Date** (mmddyyyy) for the requested start of service date. *Always required.
3. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. *Always required.
4. Enter the **Frequency** 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. *Always required.

Example: If one unit per week is needed, enter:

* Frequency

/

5. Use the **Schedule** drop-down list to select the appropriate details for the requested service. If the schedule selected is Other, enter the schedule in Miscellaneous TAR Information field. *Always required

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

Appointment Information		
* Appointment With (55 characters accepted)	Time (24HR)	Contact Phone
6 <input type="text"/>	7 <input type="text"/>	8 (<input type="text"/>) <input type="text"/> - <input type="text"/>
Primary Care Information		
* Physician's Name (25 characters accepted)	Phone	
9 <input type="text"/>	10 (<input type="text"/>) <input type="text"/> - <input type="text"/>	
Origin Information		
* Origin		
11 <input type="text"/>		
* Street Address (25 characters accepted)		
12 <input type="text"/>		
* City	* State	* Zip Code
13 <input type="text"/>	14 <input type="text"/>	15 <input type="text"/>

6. Enter the name of the provider, physician or medical group in the **Appointment With** field. *Always required.
7. Enter the appointment **Time** in a 24-hour format. Example: For 9:00 a.m. - enter 0900; for 2:30 p.m. - enter 1430.
8. Enter the **Contact Phone** number where the person indicated in the Appointment With field may be reached.
9. Enter the primary care **Physician's Name**. *Always required.
10. Enter the **Phone** number of the primary care physician.
11. Use the **Origin** drop-down list to select the place of service where the transport begins. *Always required.
12. Enter the **Street Address** of the origin. *Always required.
NOTE: Do not use a P.O. Box for the Street Address. Only use a physical address.
13. Enter the **City** of origin. *Always required.
14. Use the **State** drop-down list to select the state of origin. *Always required.
15. Enter the **Zip Code** of origin. *Always required.

TAR Services – All Other Provider Types

Destination Information			
* Primary Destination			
16	<input type="text" value=""/>		
* Street Address (25 characters accepted)			
17	<input type="text" value=""/>		
* City		* State	* Zip Code
18	<input type="text" value=""/>	19 <input type="text" value=""/>	20 <input type="text" value=""/>
* Miles One Way			
		21 <input type="text" value=""/>	
Second Destination			
<input type="text" value=""/>			
Street Address (25 characters accepted)			
<input type="text" value=""/>			
City		State	Zip Code
<input type="text" value=""/>		<input type="text" value=""/>	<input type="text" value=""/>
Miles One Way			
<input type="text" value=""/>			
Return Miles			
<input type="text" value=""/>			

16. Use the **Primary Destination** drop-down list to select the place of service where the patient is traveling. *Always required.
17. Enter the **Street Address** of the primary destination. *Always required.
18. Enter the **City** of the primary destination. *Always required.
19. Use the **State** drop-down list to select the state of the primary destination. *Always required.
20. Enter the **Zip Code** of the primary destination. *Always required.
21. Enter the number of **Miles One Way** to return to the origin address. If a three-way trip is requested, enter the number of miles from the origin to the secondary destination. *Always required.

Second Destination

22

Street Address (25 characters accepted)

23

City

24

State

25

Zip Code

26

Miles One Way

27

Return Miles

28

Transportation service codes & Total Units

* Code	* Units	Code	Units
29	30		

Enter Miscellaneous TAR Information (500 characters accepted)

31

22. For three-way trips, use the **Second Destination** drop-down list to select the place of service where the patient is traveling as a second destination.
23. Enter the **Street Address** of the primary destination.
24. Enter the **City** of the primary destination.
25. Use the **State** drop-down list to select the state of the primary destination.
26. Enter the **Zip Code** of the primary destination.
27. Enter the number of **Miles One Way** to return to the origin address. If a three-way trip is requested, enter the number of miles from the primary to the secondary destination.
28. Enter the **Return Miles** between the secondary destination and the origin.
29. Enter the service **Code** to identify the service being requested. At least one code must be entered. *Always required.
30. Enter the total number of **Units** requested. This field must be completed for each code that is entered. *Always required.
31. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Service

Patient assessment information for this Service (Attachment A)

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

32 33 Hrs/Day Days/Wk

Height Weight

34 ' " 35 lbs. oz.

* Please list current functional limitation/physical condition codes

36

Please list previous functional limitation/physical condition codes

37

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

38

32. Use the **P.O.T. Adherence** drop-down list to select the level of compliance the patient has to the Plan of Treatment.
33. Enter the number 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.
34. Enter the patient's **Height** in feet and inches.
35. Enter the patient's **Weight** in pounds and ounces.
36. 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.
37. 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.
38. Enter current medical status codes that 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 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
39	40		41

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

42

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

43

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

44

39. Use the **ICD-CM Type** drop-down list to select the ICD code type.
 40. Enter secondary **ICD Code**, including the decimal point, indicating the diagnosis relative to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search. *Always required.
- NOTE:** The **Diagnosis Description** field is no longer in use. Leave this field blank.
41. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
 42. 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.
 43. 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.
 44. 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.

TAR Services – All Other Provider Types

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

Service Code (HCPCS Code)	Describe Alternative Tried/Considered (30 characters accepted)
45	46
	Reason 47
	Reason
	Reason
	Reason
Please explain why the least costly method of treatment is not being used. (255 characters accepted)	
48	

45. 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.
46. 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.
47. 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.
48. 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)

49

* Physician's License #

50

* Physician's Name

51

* Physician's Phone

52

* Prescription Date

53

Attachment A Service

54 Continue

55 Another Service, Same Category

49. 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.
50. 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.
51. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
52. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
53. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.
54. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.
55. Click **Another Service, Same Category** to create another service line for the same service type.

Section 11. Contact Lens

Vision Service

[eTAR Medical Tutorials](#)

Please Enter Contact Lens Information

[Attachment A](#)
[Attachment G](#)

Service Information

* **Service Code** (HCPCS Code) * **Modifiers**

1 2

Service Description (40 characters accepted)

3

* **Total Units** * **From Date** * **Thru Date**

4 5 6

* **POS** Rendering Provider #

7

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it populates automatically. 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 Modifiers link to access Code Search. See Module J for more information on Code Search. *Always required.
3. Enter the **Service Description** if an unlisted, generic or miscellaneous service code is used. Otherwise, leave this field blank.
4. Enter the **Total Units** requested. *Always required.
5. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. *Always required.
6. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. *Always required.
7. Use the **POS** drop-down list to select the location where the service is being rendered. *Always required.

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

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

- 8**: Rendering Provider #
- 9**: Pricing Override Request
- 10**: Price
- 11**: MSRP
- 12**: * ICD-CM Type
- 13**: * ICD Code (Decimal Required)
- Diagnosis Description
- 14**: Date of Onset (mmddyyyy)
- 15**: Enter Miscellaneous TAR Information (500 characters accepted)

8. Enter a **Rendering Provider #** if the rendering provider is different from the submitting provider. This allows another provider to inquire on TAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
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 the decimal point for unlisted items or prices, up to seven digits. If Pricing Override Request is selected, this field is required.
11. Enter the **MSRP** (Manufacturer's Suggested Retail Price) or actual invoice price for the service being requested, up to seven digits.
12. Use the **ICD-CM Type** drop-down list to select the ICD code type.
13. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search. *Always required.

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

14. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
15. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

TAR Services – All Other Provider Types

Patient assessment information for this Service (Attachment A)

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

16

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

17

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

18

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
19 <input type="text"/> ▼	20 <input type="text"/>	<input type="text"/>	21 <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"/>

16. 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.
17. 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.
18. Enter current medical status codes that 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 link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes.
19. Use the **ICD-CM Type** drop-down list to select the ICD code type.
20. Enter secondary **ICD Code**, including the decimal point, indicating the diagnosis relative 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.

21. 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

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

24

- 22. 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.
- 23. 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.
- 24. 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.

TAR Services – All Other Provider Types

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)
25	26
	Reason 27
	Reason

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

28

25. 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.
26. 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
27. 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.
28. 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)

29

Physician's License # 30

Physician's Name 31

Physician's Phone 32

Prescription Date 33

29. 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.
30. 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.
31. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
32. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
33. 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 "Vision Attachment Form (Attachment G)". The form contains the following elements:

- Date of Comprehensive Eye Exam:** A text input field with a placeholder "mmddyyyy" and a circled number 34 next to it.
- Date of Prior Eye Exam:** A text input field with a placeholder "mmddyyyy" and a circled number 35 next to it.
- * First Time Wearer:** Two radio buttons labeled "No" and "Yes". The "No" button is selected, and it has a circled number 36 next to it.
- * Replacement?:** Two radio buttons labeled "No" and "Yes". The "No" button is selected, and it has a circled number 37 next to it.
- Replacement Reason:** Three stacked drop-down menus, each with a downward arrow icon. The top one has a circled number 38 next to it.

34. Enter the **Date of Comprehensive Eye Exam** (mmddyyyy).
35. Enter the **Date of the Prior Eye Exam** (mmddyyyy).
36. Click the circular **First Time Wearer** radio button to indicate whether or not the patient is wearing Contact Lenses for the first time. This replaces the need for submitting this information as an attachment. *Always required.
37. 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.
38. If the circular Replacement radio button was 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.

	Right Eye (OD)	Left Eye (OS)
Uncorrected Visual Acuity		
<i>Distance</i>	<input type="text" value="39"/>	<input type="text"/>
<i>Near</i>	<input type="text" value="40"/>	<input type="text"/>
Refraction Results		
* <i>Sphere</i>	<input type="text" value="41"/> Diopters	<input type="text"/> Diopters
* <i>Cylinder</i>	<input type="text" value="42"/> Diopters	<input type="text"/> Diopters
* <i>Axis</i>	<input type="text" value="43"/> Degrees	<input type="text"/> Degrees
* <i>Add Power</i>	<input type="text" value="44"/> Diopters	<input type="text"/> Diopters

- 39. Enter the right and left eye **Distance** visual acuity measured without spectacles (measurement of ability to distinguish fine detail).
- 40. Enter the right and left eye **Near** visual acuity measured without spectacles (measurement of ability to distinguish fine detail).
- 41. Enter the right and left eye **Sphere** power (nearsighted or farsighted) of the spectacle prescription. This replaces the need for submitting this information as an attachment. *Always required.
- 42. Enter the right and left eye **Cylinder** power (astigmatism) of the spectacle prescription. This replaces the need for submitting this information as an attachment. *Always required.
- 43. Enter the right and left eye **Axis** (direction of the cylinder power) of the spectacle prescription. This replaces the need for submitting this information as an attachment. *Always required.
- 44. Enter the right and left eye **Add Power** (magnification power added to sphere power for near vision). This replaces the need for submitting this information as an attachment. *Always required.

Best Corrected Visual Acuity		
* Distance	45 <input type="text"/>	<input type="text"/>
Near	46 <input type="text"/>	<input type="text"/>
* Keratometry	47 <input type="text"/>	<input type="text"/>
* Grade of Mire Distortion	48 <input type="text"/>	<input type="text"/>
* Manufacturer	49 <input type="text"/>	<input type="text"/>
* Model	50 <input type="text"/>	<input type="text"/>
* Wear	51 <input checked="" type="radio"/> Extended <input type="radio"/> Daily	<input checked="" type="radio"/> Extended <input type="radio"/> Daily
* Wearing Schedule	52 <input type="text"/>	<input type="text"/>

45. Enter the right and left eye **Distance** visual acuity measured with spectacles (measurement of ability to distinguish fine detail). This replaces the need for submitting this information as an attachment. *Always required.
46. Enter the right and left eye **Near** visual acuity measured with spectacles (measurement of ability to distinguish fine detail).
47. Enter the right and left eye measurement of anterior curvature of the cornea in the **Keratometry** fields. This replaces the need for submitting this information as an attachment. *Always required.
48. Enter the amount of right and left eye distortion in the luminous pattern of mire images in the **Grade of Mire Distortion** fields. This replaces the need for submitting this information as an attachment. *Always required.
49. Enter the name of the **Manufacturer** of the requested eye appliance. This replaces the need for submitting this information as an attachment. *Always required.
50. Enter the **Model** number or name of the requested eye appliance in the right and left eye. This replaces the need for submitting this information as an attachment. *Always required.
51. Click the circular **Wear** radio button to indicate if the patient will wear daily or extended contact lenses. This replaces the need for submitting this information as an attachment. *Always required.
52. Use the **Wearing Schedule** drop-down lists to select the wearing schedule of the right and left contact lens. This replaces the need for submitting this information as an attachment. *Always required.

Contact Lens	
*Base Curve	<div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 150px; height: 25px; margin-right: 10px;">53</div> <div style="border: 1px solid black; width: 150px; height: 25px;"></div> </div>
*Diameter	<div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 100px; height: 25px; margin-right: 10px;">54</div> <div style="margin-right: 10px;">mm</div> <div style="border: 1px solid black; width: 100px; height: 25px; margin-right: 10px;"></div> <div>mm</div> </div>
*Power	<div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 100px; height: 25px; margin-right: 10px;">55</div> <div style="margin-right: 10px;">Diopters</div> <div style="border: 1px solid black; width: 100px; height: 25px; margin-right: 10px;"></div> <div>Diopters</div> </div>
*Visual Acuity thru Eye Appliances	<div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 100px; height: 25px; margin-right: 10px;">56</div> <div style="border: 1px solid black; width: 100px; height: 25px;"></div> </div>
<hr/> <div style="display: flex; justify-content: space-between; align-items: center;"> Attachment A Attachment G Services <div style="display: flex; gap: 20px;"> <div style="border: 1px solid black; padding: 5px; border-radius: 5px;">57 Continue</div> <div style="border: 1px solid black; padding: 5px; border-radius: 5px;">58 Another Service, Same Category</div> </div> </div>	

53. Enter the right and left eye **Base Curve** of the posterior surface in the area corresponding to the optic zone. This replaces the need for submitting this information as an attachment. *Always required.
54. Enter the right and left eye **Diameter** for the contact lens in millimeters. This replaces the need for submitting this information as an attachment. *Always required.
55. Enter the right and left eye **Power** of the contact lens. This replaces the need for submitting this information as an attachment. *Always required.
56. Enter the right and left eye near **Visual Acuity thru eye Appliances**. This replaces the need for submitting this information as an attachment. *Always required.
57. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.
58. Click **Another Service, Same Category** to create another service line for the same service type.

Section 12. Low Vision Aids

Vision Service

eTAR Medical Tutorials

Please Enter Low Vision Aids Information

[Attachment A](#)
[Attachment G](#)

Service Information

* **Service Code (HCPCS Code)** * **Modifiers**

1 2

Service Description (40 characters accepted)

3

* **Total Units** * **From Date** * **Thru Date**

4 5 6

* **POS** Rendering Provider #

7

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it populates automatically. 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 Modifiers link to access Code Search. See Module J for more information on Code Search. *Always required.
3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave this field blank.
4. Enter the **Total Units** requested. *Always required.
5. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. *Always required.
6. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. *Always required.
7. Use the **POS** drop-down list to select the location where the service is being rendered. *Always required.

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

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

- 8**: Rendering Provider # (text input)
- 9**: Pricing Override Request (dropdown menu)
- 10**: Price (text input)
- 11**: MSRP (text input)
- 12**: * ICD-CM Type (dropdown menu)
- 13**: * ICD Code (Decimal Required) (text input)
- Diagnosis Description (text input)
- 14**: Date of Onset (text input with mask 'mmddyyyy')
- 15**: Enter Miscellaneous TAR Information (500 characters accepted) (large text area)

8. Enter a **Rendering Provider #** if the rendering provider is different from the submitting provider. This allows another provider to inquire on TAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
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 the decimal point, for unlisted items or prices, up to seven digits. If Pricing Override Request is selected, this field is required.
11. Enter the **MSRP** (Manufacturer’s Suggested Retail Price) or actual invoice price for the requested service. Enter this as a one through seven digit number with decimal point.
12. Use the **ICD-CM Type** drop-down list to select the ICD code type.
13. Enter the **ICD Code** indicating the primary diagnosis relative to the requested service, including the decimal point. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search. *Always required.

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

14. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
15. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Patient assessment information for this Service (Attachment A)

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

16

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

17

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

18

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
19 <input type="text"/> ▼	20 <input type="text"/>	<input type="text"/>	21 <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"/>

16. 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.
17. 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.
18. Enter current medical status codes that 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 link to access Code Search. See Module J for more information on Code Search. See Appendix A or a list of medical status codes.
19. Use the **ICD-CM Type** drop-down list to select the ICD code type.
20. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search. *Always required.

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

21. 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

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

24

- 22. 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.
- 23. 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.
- 24. 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)
25	26
Reason	27
Reason	

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

28

25. 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.
26. 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.
27. 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.
28. Enter a brief explanation in the **Please explain why the least costly method of treatment is not being used** field.

- 29. 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
- 30. 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.
- 31. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
- 32. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
- 33. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.

Attachment A Service

Vision Attachment Form (Attachment G)

Date of Comprehensive Eye Exam Date of Prior Eye Exam Professional Time Spent Hr Min

* Replacement? No Yes

Replacement Reason

Right Eye (OD) Left Eye (OS)

34. Enter the **Date of the Comprehensive Eye Exam** (mmddyyyy).
35. Enter the **Date of the Prior Eye Exam** (mmddyyyy).
36. Enter the **Professional Time Spent** in hours and minutes in fitting, training and counseling the patient on the use of the low vision aids.

Example: If three hours and four minutes are spent, enter:

Professional Time Spent
 Hr Min

37. Click the circular **Replacement?** radio button to indicate whether the requested service is a substitute of a previous item received or authorized for the patient. This replaces the need for submitting this information as an attachment. *Always required.
38. If the circular Replacement radio button is selected as “Yes”, use the drop-down lists on the **Replacement Reason** field to select up to three reasons why the item previously received or authorized for the patient is being replaced.

	Right Eye (OD)	Left Eye (OS)
Uncorrected Visual Acuity		
<i>Distance</i>	<input type="text"/>	<input type="text"/>
<i>Near</i>	<input type="text"/>	<input type="text"/>
Refraction Results		
* <i>Sphere</i>	<input type="text"/> Diopters	<input type="text"/> Diopters
* <i>Cylinder</i>	<input type="text"/> Diopters	<input type="text"/> Diopters
* <i>Axis</i>	<input type="text"/> Degrees	<input type="text"/> Degrees
* <i>Add Power</i>	<input type="text"/> Diopters	<input type="text"/> Diopters
Best Corrected Visual Acuity		
* <i>Distance</i>	<input type="text"/>	<input type="text"/>
<i>Near</i>	<input type="text"/>	<input type="text"/>

- 39. Enter the right and left eye **Distance** visual acuity measured without spectacles (measurement of ability to distinguish fine detail).
- 40. Enter the right and left eye **Near** visual acuity measured without spectacles (measurement of ability to distinguish fine detail).
- 41. Enter the right and left eye **Sphere** power (nearsighted or farsighted) of the spectacle prescription. This replaces the need for submitting this information as an attachment. *Always required.
- 42. Enter the right and left eye **Cylinder** power (astigmatism) of the spectacle prescription. This replaces the need for submitting this information as an attachment. *Always required.
- 43. Enter the right and left eye **Axis** (direction of the cylinder power) of the spectacle prescription. This replaces the need for submitting this information as an attachment. *Always required.
- 44. Enter the right and left eye **Add Power** (magnification power added to sphere power for near vision). This replaces the need for submitting this information as an attachment. *Always required.
- 45. Enter the right and left eye **Distance** visual acuity measured with spectacles (measurement of ability to distinguish fine detail). This replaces the need for submitting this information as an attachment. *Always required.
- 46. Enter the right and left eye **Near** visual acuity measured with spectacles (measurement of ability to distinguish fine detail).

* Type of Visual Field Defects (47) [dropdown] [dropdown]

Visual Field Constriction (48) [text box] Degrees [text box] Degrees

* Visual Acuity thru Eye Appliances (49) [text box] [text box]

* Sensitivity To Glare (50) [dropdown]

* Manufacturer (51) [text box] * Model (52) [text box] * Model Description (53) [text box]

* Purpose of Low Vision Aid [text area]

[Attachment A](#) [Attachment G](#) [Services](#)

47. Use the **Type of Visual Field Defects** drop-down list to select the type of visual field defect in the right and left eye. This replaces the need for submitting this information as an attachment. *Always required.
48. Enter the amount of **Visual Field Constriction** in the right and left eye in degrees.
49. Enter the right and left eye near visual acuity (measurement of ability to distinguish fine detail) measured with requested eye appliance in the **Visual Acuity thru Eye Appliances** field. This replaces the need for submitting this information as an attachment. *Always required.
50. Use the **Sensitivity to Glare** drop-down list to select the degree of annoyance, discomfort or loss in visual performance caused by light. This replaces the need for submitting this information as an attachment. *Always required.
51. Enter the name of the **Manufacturer** of the requested eye appliance. This replaces the need for submitting this information as an attachment. *Always required.
52. Enter the **Model** number or name of the requested eye appliance. This replaces the need for submitting this information as an attachment. *Always required.
53. Enter the **Model Description** of the low vision aid. (Example: 2.8X monocular telescope). This replaces the need for submitting this information as an attachment. *Always required.

* Type of Visual Field Defects [dropdown] [dropdown]

Visual Field Constriction [input] Degrees [input] Degrees

* Visual Acuity thru Eye Appliances [input] [input]

* Sensitivity To Glare [dropdown]

* Manufacturer [input] * Model [input] * Model Description [input]

* Purpose of Low Vision Aid [text area]

Attachment A Attachment G Services

55 Continue 56 Another Service, Same Category

54. Enter the **Purpose of Low Vision Aid**. This replaces the need for submitting this information as an attachment. *Always required.

55. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.

56. Click **Another Service, Same Category** to create another service line for the same service type.

Section 13. Other Eye Appliances

Vision Service

[eTAR Medical Tutorials](#)

Please Enter Other Eye Appliances Information

[Attachment A](#)
[Attachment G](#)

Service Information

* **Service Code** (HCPCS Code) * **Modifiers**

1 2

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

3

* **Total Units** * **From Date** * **Thru Date**

4 5 6

* **POS** * **Rendering Provider #**

7

1. Enter the **Service Code** identifying the service being requested. If the code was entered in the Service Code Search, it populates automatically. 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 Modifiers link to access Code Search. See Module J for more information on Code Search. *Always required.
3. Enter the **Service Description** if an unlisted, generic or miscellaneous service code is used. Otherwise, leave this field blank.
4. Enter the **Total Units** requested. *Always required.
5. Enter the **From Date** (mmddyyyy) for the requested start of service date. *Always required.
6. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. *Always required.
7. Use the **POS** drop-down list to select the location where the service is being rendered. *Always required.

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

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

- Field 8: Rendering Provider #
- Field 9: Pricing Override Request
- Field 10: Price
- Field 11: MSRP
- Field 12: * ICD-CM Type
- Field 13: * ICD Code (Decimal Required)
- Field 14: Date of Onset (mmddyyyy)
- Field 15: Enter Miscellaneous TAR Information (500 characters accepted)

8. Enter a **Rendering Provider #** if the rendering provider is different from the submitting provider. This allows another provider to inquire on TAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
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 the decimal point for unlisted items or prices, up to seven digits. If Pricing Override Request is selected, this field is required.
11. Enter the **MSRP** (Manufacturer's Suggested Retail Price) or actual invoice price for the requested service. Enter this as a one through seven digit number with decimal points.
12. Use the **ICD-CM Type** drop-down list to select the ICD code type.
13. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code link to access Code Search. See Module J for more information on Code Search. *Always required.

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

14. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
15. **Enter Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

TAR Services – All Other Provider Types

Patient assessment information for this Service (Attachment A)

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

16

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

17

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

18

ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
19 <input type="text"/> ▼	20 <input type="text"/>	<input type="text"/>	21 <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"/>

16. 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.
17. 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.
18. Enter current medical status codes that 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 link to access Code Search. See Module J for more information on Code Search. See Appendix A for a list of medical status codes.
19. Use the **ICD-CM Type** drop-down list to select the ICD code type.
20. Enter the **ICD Code**, including the decimal point, indicating the secondary diagnosis relative 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.
21. 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

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

24

- 22. 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.
- 23. 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.
- 24. In the **Please summarize the therapeutic goal to be met with the requested service(s)** field, enter a summary of the therapeutic goal.

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)
25	26
	Reason 27
	Reason
Please explain why the least costly method of treatment is not being used. (255 characters accepted)	
28	

25. 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.
26. 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.
27. 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.
28. 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)

29

Physician's License #

30

Physician's Name

31

Physician's Phone

32

Prescription Date

33

29. 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
30. 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.
31. Enter the prescribing **Physician's Name**. This replaces the need for submitting this information as an attachment. *Always required.
32. Enter the **Physician's Phone** number. This replaces the need for submitting this information as an attachment. *Always required.
33. Enter the **Prescription Date** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.

Attachment A Service

Vision Attachment Form (Attachment G)

* Date of Comprehensive Eye Exam
 34

* Replacement? 35 No Yes

Replacement Reason 36

	Right Eye (OD)	Left Eye (OS)
Uncorrected Visual Acuity		
Distance	<input type="text"/> 37	<input type="text"/>
Near	<input type="text"/> 38	<input type="text"/>
Refraction Results		
* Sphere	<input type="text"/> 39 Diopters	<input type="text"/> Diopters
* Cylinder	<input type="text"/> 40 Diopters	<input type="text"/> Diopters

34. Enter the **Date of the Comprehensive Eye Exam** (mmddyyyy). This replaces the need for submitting this information as an attachment. *Always required.
35. 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.
36. 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.

	Right Eye (OD)	Left Eye (OS)
Uncorrected Visual Acuity		
<i>Distance</i>	<input type="text" value="37"/>	<input type="text"/>
<i>Near</i>	<input type="text" value="38"/>	<input type="text"/>
Refraction Results		
* <i>Sphere</i>	<input type="text" value="39"/> Diopters	<input type="text"/> Diopters
* <i>Cylinder</i>	<input type="text" value="40"/> Diopters	<input type="text"/> Diopters
* <i>Axis</i>	<input type="text" value="41"/> Degrees	<input type="text"/> Degrees
* <i>Add Power</i>	<input type="text" value="42"/> Diopters	<input type="text"/> Diopters

- 37. Enter the right and left eye **Distance** visual acuity measured with spectacles (measurement of ability to distinguish fine detail).
- 38. Enter the right and left eye **Near** visual acuity measured with spectacles (measurement of ability to distinguish fine detail).
- 39. Enter the right and left eye **Sphere** power (nearsighted or farsighted) of the spectacle prescription. This replaces the need for submitting this information as an attachment. *Always required.
- 40. Enter the right and left eye **Cylinder** power (astigmatism) of the spectacle prescription. This replaces the need for submitting this information as an attachment. *Always required.
- 41. Enter the right and left eye **Axis** (direction of the cylinder power) of the spectacle prescription. This replaces the need for submitting this information as an attachment. *Always required.
- 42. Enter the right and left eye **Add Power** (magnification power added to sphere power for near vision). This replaces the need for submitting this information as an attachment. *Always required.

TAR Services – All Other Provider Types

Best Corrected Visual Acuity		
* Distance	<input type="text" value="43"/>	<input type="text"/>
Near	<input type="text" value="44"/>	<input type="text"/>
Keratometry	<input type="text" value="45"/>	<input type="text"/>
Grade of Mire Distortion	<input type="text" value="46"/>	<input type="text"/>
Type of Visual Field Defects	<input type="text" value="47"/>	<input type="text"/>
Visual Field Constriction	<input type="text" value="48"/> Degrees	<input type="text"/> Degrees
* Visual Acuity thru Eye Appliances	<input type="text" value="49"/>	<input type="text"/>
Sensitivity To Glare	<input type="text" value="50"/>	
Attachment A Attachment G Services		
<input type="button" value="51 Continue"/> <input type="button" value="52 Another Service, Same Category"/>		

43. Enter the right and left eye **Distance** visual acuity measured with spectacles (measurement of ability to distinguish fine detail). This replaces the need for submitting this information as an attachment. *Always required.
44. Enter the right and left eye **Near** visual acuity measured with spectacles (measurement of ability to distinguish fine detail).
45. Enter the **Keratometry** of the right and left eye measurement of anterior curvature of the cornea.
46. Enter of the amount **Grade of Mire Distortion** of right and left eye in the luminous pattern of mire images.
47. Use the **Type of Visual Field Defects** drop-down list to select the type of visual field defect in the right and left eye.
48. Enter the amount of **Visual Field Constriction** in the right and left eye in degrees.
49. Enter the right and left eye near visual acuity (measurement of ability to distinguish fine detail) measured with requested eye appliance in the **Visual Acuity thru Eye Appliances** field. This replaces the need for submitting this information as an attachment. *Always required.
50. Use the **Sensitivity to Glare** drop-down list to select the degree of annoyance, discomfort or loss in visual performance caused by light.
51. Click **Continue** to return to the TAR Service Menu. See Module E for information on submitting the TAR.
52. Click **Another Service, Same Category** to create another service line for the same service type.