

TRANSMITTAL FORM**TAR****APPEAL****CORRECTION****INSTRUCTIONS:**

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

DELIVERY METHOD: MAIL FAX ONSITE**FACILITY INFORMATION:**

Name _____	National Provider Identifier (NPI) _____
Address _____	
City and ZIP _____	Contact Person _____
Phone () _____	Fax () _____ Date Sent _____

Date Stamp
Initials _____
STATE USE ONLY

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

For STATE use only:

PAGE _____ OF _____ (including this form)

Date Returned to Facility: _____

Returned By: _____

This information is for the sole use of the intended recipient and may contain confidential and privileged information. Any unauthorized review or use including disclosure is prohibited. If you are not the intended recipient of this information, please contact the sender and destroy all copies of the documentation.