Treatment Authorization Request User Guide



eTAR User Guide: Medical Services, Allied Health, & Vision Care Services



The Outreach and Education services is made up of Provider Field Representatives located throughout California and includes the Small Provider Billing Assistance and Training Program staff, who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment. See the below additional tools and free services available to your provider community.

Medi-Cal Learning Portal (MLP)

Explore the Medi-Cal Learning Portal (MLP) that offers Medi-Cal providers and billers selfpaced online training about billing basics, related policies and procedures; new initiatives and any significant changes to the Medi-Cal program.

How can you get started using the MLP?

- First time users must complete a one-time registration at www.learn.medi-cal.ca.gov
- After logging in, you will be able to RSVP for training events or view eLearning courses
- Refer to the Medi-Cal Learning Portal (MLP) Job Aid or the Medi-Cal Learning Portal (MLP) User Guide for detailed instructions

How can you benefit from using the MLP?

- Significantly reduce billing errors by learning billing best practices
- Quizzes that test your knowledge
- Practice your skills using interactive activities

Free Services for Providers

Provider Seminars and Webinars

Provider Training Seminars and Webinars offer basic and advanced billing courses for all provider types. Seminars also offer a free billing assistance called the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Provider Field Representative. The dates and locations for the annual provider training seminars and webinars can be found on the events calendar in the MLP tool and in the News area on www.medi-cal.ca.gov.

Provider Field Representatives

Receive one-on-one assistance from Provider Field Representatives who live and work in cities throughout California. Provider Field Representatives are available to visit providers at their office to assist with billing needs and/or provide custom billing training to office staff.

Small Provider Billing Assistance and Training Program

The Small Provider Billing Assistance and Training Program is 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 Small Provider Billing Assistance and Training Program, call (916) 636-1275 or 1-800-541-5555.

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

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Select Service Category

Add Service - Category Unknown						
* Service Code Sear	rch 3					
1	Find Service Cate	gory(s)				
			e	TAR Medical Tutorials		
	Pleas	e Select a Service	Category			
	When finished	d with all services, cli	ck Submit TAR	_		
DME Services	LTC Services	Inpatient Services 2	Outpatient Services	Other Services		
 Apnea Monitor Beds Hearing Aid Incontinence Supplies IV Equipment Medical Supplies Mobility Orthotics/ Prosthetics Ox/Respiratory Pumps (non-IV) Other 	 ICF-DD NFA/NFB Non- Electronic MDS Short Stay Subacute 	 Hospital Days Hyperbaric Oxygen Radiology Surgical/Other Procedures Transplant Procedure- Kidney Transplant Procedure-Other 	 Allergy Cochlear Implants CPSP Dialysis FPACT HopTel Hyperbaric Oxygen Radiology Office Visits - Restricted Office Visits - Restricted Provider Plasma Pheresi Portable X-ray Psychiatry Surgical/Other Procedures TeleMed Transplant Acquisition 	 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 		

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There are three ways to add a service to the TAR:

- 1. If you know the code, enter the code in the search field and select **Find Service Category(s)**. This is the preferred method.
- 2. If you don't know the code, but you know the service category, select the appropriate Service Category hyperlink.
- 3. If you don't know the code or the service category, select the **Service Code Search** hyperlink to initiate the search. See the eTAR User Guide: Basics for additional information on code search.
- **Note:** For Specific Provider Types, refer to the appropriate eTAR User Guides for additional information.

Service Selection

Colort	anaronriata convice est		ruine and a listed below		eTAR Medical T
Select	appropriate service cat	egory for se	(4)		
Code	Description	Code Type	Service Category	Service Grp Desc	TAR Indicator
93303	ECHO TRANSTHORACIC	Ρ	Surgical/Other Procedure	Medicine	POS/Provider Depend., May Require TAR OR Medi Reservation
93303	ECHO TRANSTHORACIC	P	Off Visit, restricted provider	Medicine	POS/Provider Depend., May Require TAR OR Medi Reservation

If you entered the Service Code (Step 1), it may return multiple service categories for the specific code. If this is the case, select the appropriate **Service Category** hyperlink that applies to the service being requested.

Note: This screen will only appear if the service code has more than one service category

Allergy

Outpatient Services	
	eTAR Medical Tutorials
Please Enter Allergy Info	ormation
Attachment A Continue	
Service Information	
* Service Code (CPT Code)	Modifiers (if applicable)
1	
* Total Units * Frequency	* Ant. Length of Need
3 4 1	S / V

- 1. Enter the **Service Code** being requested if blank. If the service code is unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers hyperlink to access Code Search.
- 3. Enter the Total Units requested. *Required
- 4. Enter the Frequency for the number of units that will be used per time period. Enter the number of units in the first field and use the drop-down to select the time period. *Required

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

* Frequer	ıc	у	
6	1	Week	*

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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 to select the time period. *Required

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

* Ant. Length of Need	
From Date 6 Through Date 7 mmddyyyy mmddyyyy	
8 * ICD Code (Decimal Required) 9 Diagnosis Description	10 Date of Onset mmddyyyy
Enter Miscellaneous TAR Information (500 characters accepted)	*
	-

- 6. Enter the From Date (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.Enter the Through Date (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 8. Use the ICD-CM Type drop-down to select the ICD code type. *Required
- Enter the ICD Code, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *Required

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

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

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Service Conti	nue				
Patient assessme	nt information for this	Service (Attachment A)			
(12)					
* Please list current	t medical status codes	relevant to requested service(s)			
(13)	ICD Code/Desimal				
ICD-CM Type	Required) 14	Diagnosis Description			15 Date Of Onset
•					
•					
•					
Please summarize characters accept	e treatment/procedures	/surgeries/clinical findings/history	relevant to the requested	service(s) inclu	de dates if applicable. (255
	_			* *	

- 12. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status link to access Code Search. *Required
- 13. Use the ICD-CM Type drop-down to select the ICD code type.
- 14. Enter secondary **ICD Code**, including the decimal point, indicating the diagnoses relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search.

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 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.



- 17. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 18. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 19. Enter the prescribing Physician's Name. *Required
- 20. Enter the Physician's Phone number. *Required
- 21. Enter the **Prescription Date** (mmddyyyy). *Required
- 22. Click **Continue** to return to the TAR Service menu. See the eTAR User Guide: Basics for information on submitting the TAR.
- Or
- 23. Click **Another Service**, **Same Category** to create another service line for the same service type.

Comprehensive Perinatal Services Program (CPSP)

Outpatient Services	
	eTAR Medical Tutorials
Please Enter CPSP Informat	tion
Attachment A Continue	
Service Information	
* Service Code (HCPCS or CPT Code)	lodifiers (if applicable)
Service Description (40 characters accepte	ed)
* Total Units * Frequency	Ant. Length of Need

- 1. Enter the **Service Code** being requested if blank. If the service code is unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers hyperlink to access 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. *Required
- 5. Enter the **Frequency** for the number of units being requested along with the time period. Enter the number of units in the first field and use the drop-down to select the time period. *Required

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

* Frequency			
3	/ Week	*	

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* Total Units	* Frequency	Ant. Length of Need	
From Date	Thru Date mhadyyyy	Rendering Provider #	
* ICD-CM Type	* ICD Code (Decimal Required) Diag	osis Description	Date of Onset mmddyyyy
Enter Miscellaneo	ous TAR Information (500 charac	ers accepted)	
		~	

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 to select the time period.

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



- 7. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 8. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 9. Enter a **Rendering Provider #** to allow another provider to inquire on the eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
- 10.Use the ICD-CM Type drop-down to select the ICD code type. *Required
- 11. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *Required
- Note: The Diagnosis Description field is no longer in use. Leave this field blank.

* Total Units	* Frequency	•	Ant. Length of Need	
From Date	Thru Date	*	Rendering Provider #	
* ICD-CM Type	* ICD Code (Decimal Required)	Diagnosis Description		Date of Onset

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

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Service Conti	nue					
Patient assessme	Patient assessment information for this Service (Attachment A)					
P.O.T. Adherence	14)	Height 15	Weight 16			
	•	• • •	lbs. oz.			
* Please list currer	nt medical status codes	relevant to requested service(s)				
ICD-CM Type	ICD Code(Decimal Required)	Diagnosis Description	20 Date Of Onset			

- 14. Use the **P.O.T Adherence** drop-down to select the level of compliance the patient has to the Plan of Treatment.
- 15. Enter the patient's **Height** in feet and inches.
- 16. Enter the patient's Weight in pounds and ounces.
- 17 Enter current medical status codes which describe the patient's condition in **the Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status hyper link to access Code Search. *Required
- 18 Use the **ICD-CM Type** drop-down to select the ICD code type.
- 19. Enter secondary **ICD Code**, including the decimal point, indicating the diagnoses relative to the requested service. If unknown, click the ICD Code hyperlink to access 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.

	S 2
f it is known that the patient has ever received the reques nclude dates. (255 characters accepted)	ted or similar service(s), please explain
22	5 2
Please summarize the therapeutic goal to be met with the r accepted)	equested service(s). (255 characters

- 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. *Required
- 22. 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.
- 23. 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 conside	ered and the reason why they are not feasible for this patient
	Describe Alternative Tried/Considered (30 characters accepted)
(26) Reason	
Reaso	n 🗸
Reaso	n v
Reaso	n 🛛 🖌

- 24. Enter the **Service Code** that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code hyperlink to access Code Search.
- 25. 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.
- 26. Use the **Reason** drop-down to identify why the service is not feasible for this patient. If an alternative service code or description is not entered, leave the field blank.



- 27. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 28. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 29. Enter the prescribing Physician's Name. *Required
- 30. Enter the Physician's Phone number. *Required
- 31 Enter the Prescription Date (mmddyyyy). *Required
- 32 Click **Continue** to return to the TAR Service menu. See the eTAR Basics User Guide for information on submitting the eTAR.
- Or
- 33. Click **Another Service**, **Same Category** to create another service line for the same service type.

Family PACT

Outpatient S	Services		
		eTAR M	edical Tutorials
Please Enter	FPACT Informat	ion	
Service Informatio	n		
* Service Code (HC	CPCS or CPT Code)	2 Modifiers (if ap	oplicable)
Service Description	(40 characters accepte	d)	
3			
Side	* Total Units	From Date	Thru Date
4	5	6 mmddyyyy	7 mmddyyyy
Start of Care	Frequenc	Y	Ant. Length of Need
mmddyyyy		/	/

- 1. Enter the **Service Code** being requested if blank. If the service code is unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers hyperlink to access 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 to select Right, Left or Bilateral. *Required
- 5. Enter the **Total Units** requested. *Required
- 6. Enter the **From Date** (mmddyyyy) for the requested start of service date. If the request is retroactive, enter the actual dates of service. If request is planned, enter range of dates during which service will be provided.
- 7. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. If the request is retroactive, enter the actual dates of service. If request is planned, enter range of dates during which service will be provided.

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Outpatient S	ervices			
		eTAR Medical Tutorials		
Please Enter I	PACT Information			
Service Information	E			
* Service Code (HCF	CS or CPT Code)	Modifiers (if a	pplicable)	
Service Description (4	0 characters accepted)			
Side	* Total Units	From Date mmddyyyy	Thru Date mmddyyyy	
Start of Care mmddyyyy	Frequency	~	Ant. Length of Need	

- 8. Enter the **Start of Care** (mmddyyyy) date the patient began, or will begin, receiving the service requested.
- 9. Enter the **Frequency** for the number of units that will be used per time period. Enter the number of units in the first field and use the drop-down to select the time period.

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

Frequency			
3	/ Week	*	

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

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

Ant. L	ength of Need.		
1	/ Month	~	

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Discharge Date 11 mmddyyyy Discharge 12	•		
Dendering	*ICD-CM * ICD Code		
Provider # (12)	Type (Decimal Required)	Diagnosis Description	Date of Onset
			16 mmddyyyy
Enter Miscellaneous TAR	Information (500 characters accepted)		
(17)		~	
\smile			
		-	
	Continue Ar	19 other Service, Same Category	

- 11. Enter the **Discharge Date** (mmddyyyy). If Discharge has been selected, this field is required.
- 12 Use the **Discharge** drop-down to select the level of care for the patient.
- 13. If the rendering provider is different from the submitting provider, enter a **Rendering Provider #.** This will allow another provider to inquire on the eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
- 14. Use the ICD-CM Type drop-down to select the ICD code type. * Required
- 15. 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. *Required

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

- 16. Enter the Date of Onset (mmddyyyy) for the diagnosis entered in the ICD Code field.
- 17 Enter **Miscellaneous TAR Information** with additional treatment details and medical justification pertinent to the requested service.
- 18. Select **Continue** to return to the TAR Service menu. See the eTAR User Guide: Basics for information on submitting the eTAR.

Or

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

Hemodialysis

Outpatient Services	
	eTAR Medical Tutorials
Please Enter Dialysis Information	
Attachment A Continue	
Service Information	
* Service Code (HCPCS or CPT Code) 2 1 2 2	ers (if applicable)
Service Description (40 characters accepted)	
]
* Schedule	
4	
* Total Units * Frequency	Ant. Length of Need

- 1. Enter the **Service Code** being requested if blank. If the service code is unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers hyperlink to access 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 **Schedule** drop-down to select the appropriate details for the requested service. If "Other" is selected, enter the schedule in the Enter Miscellaneous TAR Information field. *Required
- 5. Enter the **Total Units** requested. *Required

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 Enter the Frequency for the number of units that will be used per time period. Enter the number of units in the first field and use the dropdown to select the time period.
 *Required

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

		3 Week		
* Total Units	* Frequency	Ant. Length	of Need	
	/		•	
From Date	Thru Date	Rendering Provider #		
mmddyyyy	mmddyyyy			
* ICD-CM Type Require	ode (Decimal	ariation		Date of Openat
		enpuon		13 mmddyyyy
Enter Miscellaneous TAR I	nformation (500 characters acce	pted)		
(14)			^	
			Ŧ	

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 to select the time period. *Required

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



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

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- 11. Use the **ICD-CM Type** drop-down to select the ICD code type. *Required
- 12. Enter the ICD Code, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *Required

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

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

ICD-CM Type Required) 15 • 16 • • • • • • • • • • • • • • • • • • •	Diagnosis Description	Date Of Onset
* Please summarize treatment/procedure characters accepted)	es/surgeries/clinical findings/history relevant to the re	equested service(s) include dates if applicable. (255
(18)		~ ~
If it is known that the patient has ever re	ceived the requested or similar service(s), please ex	plain include dates. (255 characters accepted)
(19)		~ ~
Please summarize the therapeutic goal	to be met with the requested service(s). (255 charact	ters accepted)
20		-

- 15. Use the **ICD-CM Type** drop-down to select the ICD code type.
- 16. Enter secondary **ICD Code**, including the decimal point, indicating the diagnoses relative to the requested service. If unknown, click the ICD Code hyper link to access Code Search.
- 17. 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 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. *Required

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- 20. 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.
- 21. 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.

Prescribing Physician Information	
* Physician Prescription (255 characters accepted)	
(21)	< >
* Physician's License # * Physician's Name	
* Physician's Phone (24) (24) (25) (25) (25) (25) (25) (25) (26) (26) (27) (27) (28) (29)	
Attachment A Service	
26 Continue 27 Another Service, Same Category	

- 22. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 23. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 24. Enter the prescribing Physician's Name. *Required
- 25. Enter the Physician's Phone number. *Required
- 26 Enter the Prescription Date (mmddyyyy). *Required
- 27 Click **Continue** to return to the TAR Service menu. See the eTAR User Guide: Basics for information on submitting the eTAR.

Or

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

Non-Pharmacy Issued Drug

Other Services	
	eTAR Medical Tutorials
Please Enter Non-Pharmacy Iss Service Information	ued Drug Information
* Service Code (HCPCS or CPT Code)	2 Modifiers (if applicable)
* Total Units * Frequency	5 Ant. Length of Need

- 1. Enter the **Service Code** being requested if blank. If the service code unknown, click the Service Codes hyper link, to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers hyperlink to access Code Search.
- 3. Enter the **Total Units** requested. *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 to select the time period. *Required

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

* Freque	nc	у	
3	1	Week	*

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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 to select the time period.

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

	2 / Month	➤
From Date mmddyyyy	7 mmddyyyy	8 Rendering Provider #
POS	•	
* ICD-CM Type Rec	D Code (Decimal uired) Diagnosis	Description
Enter Miscellaneous TAR	Information (500 characters accepted)	E.com
		^
		*
	13 Contin	4 Another Service, Same Category

- 6. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 7. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 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 to select the location where the service is being rendered.
- 10.Use the ICD-CM Type drop-down to select the ICD code type. *Required

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11. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *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 the eTAR Basic User Guide for information on submitting the TAR.

Or

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

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Office Visit – Restricted

Outpatien	t Services		
			eTAR Medical Tutorials
Please Ente	er Office Visit	- Restricted In	formation
Attachment A	Continue		
Service Information	n		
* Service Code (CF	T or HCPCS Code)	Modifiers (if	applicable)
Side	* Total Units	From Date 5 mmddyyyy	Thru Date 6 mmddyyyy

- 1. Enter the **Service Code** being requested if blank. If the service code unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers hyper link to access Code Search.
- 3. Use the **Side** drop-down to select Right, Left or Bilateral.
- 4. Enter the Total Units requested. *Required
- 5. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 6. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.

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* Frequency	8 Ant. Length of Need	
*ICD-CM * ICD Code		
Type (Decimal Required)	Diagnosis Description	Date of Onset
		mmddyyyy
Enter Miscellaneous TAR Information	n (500 characters accepted)	
(12)		~
		~

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

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

* Frequ	ency	
3	/ Week	*

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

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

* Ant. Length of Need			
2	1	Month	~

- 9. Use the ICD-CM Type drop-down to select the ICD code type. *Required
- 10. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *Required

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

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

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Service Continue	
Patient assessment information for this Service (Attachment A)	
P.O.T. Adherence	
Please list current functional limitation /physical condition codes	
Please list current medical status codes relevant to requested service(s)	
ICD-CM Type ICD Code (Decimal Required) Diagnosis Description	Date Of Onset

- 13.Use the **P.O.T Adherence** drop-down to select the level of compliance the patient has to the Plan of Treatment.
- 14. 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 hyper link to access Code Search.
- 15. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status hyper link to access Code Search.
- 16. Use the **ICD-CM Type** drop-down to select the ICD code type.
- 17. Enter secondary **ICD Code**, including the decimal point, indicating the diagnoses relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search.

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

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

19	~
	Y
If it is known that the patient has ever received the requested or include dates. (255 characters accepted)	similar service(s), please explain
20	~
	<u></u>
Please summarize the therapeutic goal to be met with the reques accepted)	sted service(s). (255 characters
21	~

- 19. 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. *Required
- 20. 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.
- 21. 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.

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- 22. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 23. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 24. Enter the prescribing Physician's Name. *Required
- 25. Enter the Physician's Phone number. *Required
- 26. Enter the Prescription Date (mmddyyyy). *Required
- 27. Click **Continue** to return to the TAR Service menu. See the eTAR User Guide: Basics for information on submitting the eTAR.

Or

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

Office Visit – Restricted Provider

Outpatient	t Services	
		eTAR Medical Tutorials
Please Ente	r Office Visit -	Restricted Provider Information
Attachment A	Continue	
Service Information	n	
* Service Code (CP	T or HCPCS Code)	(2) Modifiers (if applicable)
Side	* Total Units	Ant. Length of Need

- 1. Enter the **Service Code** being requested if blank. If the service code is unknown, click the Service Code hyperlink to access Code Search. See eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers hyperlink to access Code Search.
- 3. Use the **Side** drop-down list to select Right, Left or Bilateral.
- 4. Enter the Total Units requested. *Required

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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 to select the time period.

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

Ant. Length of Need	
From Date Rendering Provider #	
mmddyyyy mmddyyyy 8	
* ICD Code (Decimal	
* ICD-CM Type Required) Diagnosis Description	Date of Onset
9	mmddyyyy
Enter Miscellaneous TAR Information (500 characters accepted)	
(12)	
· · · · · · · · · · · · · · · · · · ·	

- 6. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 7. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 8. Enter a **Rendering Provider #** if rendering provider is different from the submitting provider. This will allow another provider to inquire on the eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
- 9. Use the ICD-CM Type drop-down to select the ICD code type. *Required
- 10. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *Required

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

- 11.Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code. *Required
- 12. Enter **Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.
| Service Continue | | | | |
|---|--|--|--|--|
| Patient assessment information for this Service (Attachment A) | | | | |
| *P.O.T. Adherence *Height *Weight
13 * 14 * 15 lbs. oz. | | | | |
| * Please list current functional limitation /physical condition codes | | | | |
| Please list previous functional limitation /physical condition codes | | | | |
| * Please list current medical status codes relevant to requested service(s) | | | | |

- 13.Use the **P.O.T Adherence** drop-down to select the level of compliance the patient has to the Plan of Treatment. *Required
- 14. Enter the patient's **Height** in feet and inches. *Required
- 15. Enter the patient's Weight in pounds and ounces. *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 hyper link to access Code Search. *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.
- 18. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status link to access Code Search. *Required

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2D-CM Type Required) 91 (201)	Diagnosis Description	Date Of Onset
•		
Please summarize treatment/procedure	s/surgeries/clinical findings/history relevant to the req	uested service(s) include dates if applicable. (25
		-
t is known that the patient has ever rec	eived the requested or similar service(s), please expl	ain include dates. (255 characters accepted)
2)		
9)		
2) sase summarize the therapeutic goal to	be met with the requested service(s). (255 characte	rs accepted)
ease summarize the therapeutic goal to	be met with the requested service(s). (255 characte	rs accepted)

- 19. Use the **ICD-CM Type** drop-down to select the ICD code type.
- 20. Enter secondary **ICD Code**, including the decimal point, indicating the diagnoses relative to the requested service. If unknown, click the ICD Code hyper link to access Code Search.

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

- 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. *Required
- 22. 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.
- 23. 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.

vice Code 24	Describe Alternative Tried/0	onsidered (30 characters ac	ce
Reaso	26	~	
Reaso]n	~	
Reaso	n	*	
ase explain why the least costly i	method of treatment is not bein	g used. (255 characters acce	pt

- 24. Enter the **Service Code** that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code hyper link to access Code Search.
- 25. 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.
- 26. Use the **Reason** drop-down 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.
- 27. Enter a brief explanation in the Please explain why the least costly method of treatment is not being used field. *Required

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Prescribing Physician Information				
* Physician Prescription (255 characters accepted)				
* Physician's License # 29 30 30				
* Physician's Phone * Prescription Date				
Attachment A Service				
Continue Another Service, Same Category				

- 28. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 29. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 30. Enter the prescribing Physician's Name. *Required
- 31. Enter the **Physician's Phone** number. *Required
- 32. Enter the Prescription Date (mmddyyyy). *Required
- 33. Click **Continue** to return to the TAR Service menu. See the eTAR User Guide: Basics for information on submitting the eTAR.

Or

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

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Psychiatry

Outpatient Services		
	eTAR Medical Tutorials	
Please Enter Psychiatry Inf	ormation	
Attachment A Continue		
Service Information		
* Service Code (HCPCS or CPT Code)	2 Modifiers (if applicable)	
Service Description (40 characters accept	ted)	
* Total Units * Frequency	Ant. Length of Need	
	· / ·	

- 1. Enter the **Service Code** being requested if blank. If the service code is unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers hyperlink to access 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. *Required
- Enter the Frequency for the number of units that will be used per time period. Enter the number of units in the first field and use the drop-down to select the time period.
 *Required

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



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* Total Units	* Frequency	6 Ant. Length of	Need	
From Date 7 mddyyyy	Thru Date 8 mmddyyyy	9 Rendering Provider #		
* ICD-CM Type Re 10 11	D Code (Decimal quired) Diagnosis	s Description		12 Date of Onset mmddyyyy
Enter Miscellaneous T	AR Information (500 characters	accepted)	•	
			~	

6. Enter the **Ant. Length of Need** to indicate the appropriate period of the requested services.

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

Ant. Length of Need			
2	1	Month	~

- 7. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 8. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 9. Enter a **Rendering Provider #** if rendering provider is different from the submitting provider. This will allow another provider to inquire on the eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
- 10. Use the ICD-CM Type drop-down to select the ICD code type.*Required
- 11. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyper link to access Code Search. *Required

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

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

Service Continue				
Patient assessment information for this Service (Attachment A)				
* P.O.T. Adherence	15 V			
Height	Weight 17 Ibs. oz.			
Please list current functional limit	tation /physical condition codes			
Please list previous functional lim	itation /physical condition codes			
Please list current medical status codes relevant to requested service(s)				

- 14. Use the **P.O.T Adherence** drop-down to select the level of compliance the patient has to the Plan of Treatment. *Required
- 15. Use the **Feeding Method** drop-down to select the method of feeding for the patient.
- 16. Enter the patient's Height in feet and inches. *Required
- 17. Enter the patient's Weight in pounds and ounces. *Required
- 18. 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. *Required

Service Continue				
Patient assessment information for this Service (Attachment A)				
* P.O.T. Adherence	Feeding Method			
~	✓			
Height	Weight			
	lbs. oz.			
Please list current functional limitation	on /physical condition codes			
Please list previous functional limita	tion /physical condition codes			
Please list current medical status co	ides relevant to requested service(s)			

- 19. 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.
- 20. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status hyperlink to access Code Search. *Required.

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ICD-CM Type	ICD Code(Decimal Required)	Diagnosis Description		Date Of Onset
21 💽 🤇	22			23
* Please summa characters accer	rize treatment/procedure	s/surgeries/clinical findings/history relevant to th	ne requested service(s)	include dates if applicable. (255
24)			*	
			*	
If it is known that	t the patient has ever rea	eived the requested or similar service(s), please	e explain include date	s. (255 characters accepted)
lf it is known that	t the patient has ever rea	eived the requested or similar service(s), please	e explain include date	s. (255 characters accepted)
If it is known that	t the patient has ever rea	eived the requested or similar service(s), please	e explain include date	s. (255 characters accepted)
If it is known that Please summari:	t the patient has ever rea	eived the requested or similar service(s), please b be met with the requested service(s). (255 cha	e explain include date • • • • • • • • • • • • • • • • • • •	s. (255 characters accepted)
If it is known that	t the patient has ever red ze the therapeutic goal t	eived the requested or similar service(s), please o be met with the requested service(s). (255 cha	e explain include dater	s. (255 characters accepted)

- 21. Use the **ICD-CM Type** drop-down to select the ICD code type.
- 22. Enter secondary **ICD Code**, including the decimal point, indicating the diagnoses relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search.

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

- 23. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
- 24. Enter a summary of the treatment and history of the patient in the **Please summarize** treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable field.

25	ice(s), please explain include dates. (255 characters accepted)
Please summarize the therapeutic goal to be met with the requested service 26	r(s). (255 characters accepted)
Please list service codes for alternatives tried considered 27	

- 25. Enter information regarding any similar services in the **If it is known that the patient has ever received the requested or similar service(s), please explain include dates** field.
- 26. Enter a summary of the therapeutic goal to be met in the **Please summarize the therapeutic goal to be met with the requested service(s)** field.
- 27. Enter a service code in the **Please list service codes for alternatives tried considered** field. If unknown, click the Service Code hyperlink to access Code Search.

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Prescribing Physician Information Physician Prescription (255 characters accepted)	
(28)	
Physician's License #	30 Physician's Name
Physician's Phone	32 Prescription Date
Attachment A Service	
³³ Continue ³⁴ Another	Service, Same Category

- 28. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 29. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 30. Enter the prescribing Physician's Name. *Required
- 31. Enter the Physician's Phone number. *Required
- 32. Enter the **Prescription Date** (mmddyyyy). *Required
- 33. Click **Continue** to return to the TAR Service menu. See the eTAR Basics User Guide for information on submitting the eTAR.

Or

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

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Radiology

Outpatient Services
eTAR Medical Tutorials
Please Enter Radiology Information
Attachment A Continue
Service Information
* Service Code (HCPCS or CPT
Code) Modifiers (if applicable)
Service Description (40 characters accepted)
3
Side * Total Units From Date Thru Date
4 5 6 mmddyyyy mmddyyyy

- 1. Enter the **Service Code** being requested if blank. If the service code is unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers link to access 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 arrow select Right, Left or Bilateral.
- 5. Enter the Total Units requested. *Required
- 6. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 7. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.

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Rendering Provider #		
* ICD-CM * ICD C Type (Decima 9 10 Enter Miscellaneous T	AR Information (500 characters accepted)	Date of Onset
12		^

- 8. Enter a **Rendering Provider #** if rendering provider is different from the submitting provider. This will allow another provider to inquire on the eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
- 9. Use the ICD-CM Type drop-down to select the ICD code type. *Required
- 10. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyper link to access Code Search. *Required

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

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

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Rendering Pr	ovider #			
* ICD-CM Type 9 Enter Miscell	* ICD Code (Decimal Required)	Diagnosis Description	Date of Onset	
12				*
				-

- 13. Enter the patient's Weight in pounds and ounces.
- 14. 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 hyperlink to access Code Search.
- 15. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status hyper link to access Code Search. *Required
- 16.Use the ICD-CM Type drop-down to select the ICD code type.
- 17. Enter secondary **ICD Code**, including the decimal point, indicating the diagnoses relative to the requested service. If unknown, click the ICD Code hyper link to access Code Search.

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

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

requested service(s) in	clude dates if applicable. (25	5 characters accepted)
* If it is known that the pa explain include dates.	tient has ever received the rec (255 characters accepted)	uested or similar service(s), please
20)		
Please list alternatives to for this patient	ied or considered and the rea	son why they are not feasible
Service Code	Describe Alt 22(30 characte	ernative Tried/Considered ers accepted)
	Reason	~
	Bosson	
Please explain why the I accepted)	east costly method of treatmen	nt is not being used. (255 characters
		<u>_</u>

- 19. 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.
- 20. 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. *Required
- 21. Enter the **Service Code** identifying a service that has already been attempted or considered and was determined to be unfeasible for the patient. If unknown, click the Service Code hyperlink to access Code Search.
- 22. Enter details in the **Describe Alternative Tried/Considered** field. If an alternative service code has been entered in the adjacent field, leave the field blank.

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Г

	A
* If it is known that the patient has ever explain include dates. (255 character	received the requested or similar service(s), please 's accepted)
	~ ~
Please list alternatives tried or consider for this patient	red and the reason why they are not feasible
Service Code	Describe Alternative Tried/Considered (30 characters accepted)
Reas	on 🔽
Reas	on v

- 23.Use the **Reason** drop-down list to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
- 24. Enter a brief explanation in the Please explain why the least costly method of treatment is not being used field.

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- 25. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 26. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 27. Enter the prescribing Physician's Name. *Required
- 28.Enter the Physician's Phone number. *Required
- 29. Enter the Prescription Date (mmddyyyy). *Required
- 30. Click **Continue** to return to the TAR Service menu. See the eTAR User Guide: Basics for information on submitting the eTAR.

Or

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

A Medical Services Page updated: September 2020

Surgical Procedure/Other Procedures

Outpatient Services
eTAR Medical Tutorials
Please Enter Surgical Procedure Information
Attachment A Continue
Service Information
* Service Code (CPT or HCPCS Code) 1 1 2 Modifiers (if applicable)
Service Description (40 characters accepted)
Side * Total Units From Date Thru Date Admit Date 4 5 mmddyyyy mmddyyyy mmddyyyy
9 9

- 1. Enter the **Service Code** being requested if blank. If the service code is unknown, click the Service Code hyper link to access Code Search. See eTAR User Guide: Basics more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers hyper link to access 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 o select Right, Left or Bilateral.
- 5. Enter the **Total Units** requested. *Required

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- 6. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 7. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 8. Enter the date the patient was or will be admitted in the Admit Date field (mmddyyyy).
- 9. Use the **POS** drop-down to select the location where the service is being rendered.

Rendering Provider #	
* ICD-CM * ICD Code	
Type (Decimal Required) Diagnosis Description Date of Onset	
]
Enter Miscellaneous TAR Information (500 characters accepted)	
14	~
	-

- 10. Enter a **Rendering Provider #** to allow another provider to inquire on the eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
- 11.Use the **ICD-CM Type** drop-down to select the ICD code type.
- 12. Enter the ICD Code, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *Required

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

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

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Patient asse	ssment informat	ion for this Service (Attachment A)	
Height		Ueight Ibs. oz.	
Please list cu	rrent medical sta	tus codes relevant to requested service(s)	
ICD-CM Type 18 T	ICD Code (Decimal Required)	Diagnosis Description	20 Date Of Onset

- 15. Enter the patient's Height in feet and inches.
- 16. Enter the patient's Weight in pounds and ounces.
- 17. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status hyper link to access Code Search. *Required
- 18.Use the **ICD-CM Type** drop-down to select the ICD code type.
- 19. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyperlink to access 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.

Please summarize treatment/proc requested service(s) (include date	edures/surgeries/clinical findings/history relevant to the significable. (255 characters accepted)
21	
If it is known that the patient has e explain include dates. (255 char	ver received the requested or similar service(s), please acters accepted)
2)	
Please list alternatives tried or cor patient Service Code (24)	Describe Alternative Tried/Considered (30 characters) accepted)
Reasor	
Reasor	n v
Please explain why the least cost accepted)	y method of treatment is not being used. (255 characters

- 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.
- 22. 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. *Required
- 23. 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 hyperlink to access Code Search.
- 24. 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.

Please summarize treatment/pro requested service(s) (include dat	cedures/surgeries/ es if applicable. (25	clinical finding 55 characters a	s/history releva accepted)	nt to the
f it is known that the patient has e explain include dates. (255 cha	ever received the re racters accepted)	quested or sim	nilar service(s),	please
				< >
Please list alternatives tried or co atient Service Code	nsidered and the re Describe Alterna accepted)	eason why they tive Tried/Cons	y are not feasib sidered (30 cha	le for this racters
25 Reaso	n		~	
Reaso	n		~	
lease explain why the least cost ccepted)	ly method of treatm	ient is not beir	ng used. (255 c	haracters
6)				< >

- 25.Use the **Reason** drop-down 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.
- 26.Enter a brief explanation in the Please explain why the least costly method of treatment is not being used field.

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- 27. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 28. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 29. Enter the prescribing Physician's Name. *Required
- 30 Enter the Physician's Phone number. *Required
- 31. Enter the Prescription Date (mmddyyyy). *Required
- 32. Click **Continue** to return to the TAR Service menu. See the eTAR Basics User Guide for information on submitting the eTAR.

Or

- 33. Click **Another Service, Same Category** to create another service line for the same service type
- Note: TAR web pages do not have numbered fields

Allied Health Services

Select Service Category

Add Service - Category Unknown					
* Service Code Search 3					
$\bigcirc \qquad \square$	Find Service Cate	gory(s)			
			eTA	R Medical Tutorials	
	Dia		C-1	art medical ratorials	
Please Select a Service Category					
DME		Innationt	Outpatient	Other	
Services 2	Services	Services	Services	Services	
Apnea Monitor	ICF-DD	 Hospital Days 	Allergy	• AAC	
Beds	NFA/NFB Non-	 Hyperbaric 	Cochlear	ADHC	
 Hearing Aid 	Electronic MDS	Oxygen	Implants	Detox	
 Incontinence 	Short Stay	 Radiology 	• CPSP	EPSDT	
Supplies	 Subacute 	 Surgical/Other 	Dialysis	Nutritional	
IV Equipment		Transplant	• FPACT	Home Health	
 Medical Supplies 		Procedure-	HopTel	Hospice	
Mobility		Kidney	Hyperbaric	Non-Pharmacy	
Orthotics/ Prosthetics		Transplant	Dadiology	Respiratory	
Ox/Respiratory		Procedure-Other	Office Visits -	Therapy	
Pumps (non-IV)			Restricted	Speech/	
Other			Office Visits -	Occupational	
			Restricted	/Physical	
			Provider	Transportation	
			Plasma Pheresis	Vision - Contact	
			Portable X-ray	Lens / Evaluation	
			Psychiatry	Vision - Low	
			 Surgical/Other Procedures 	Vision Aids	
			TeleMed	Vision - Other	
			Transplant	Eye Appliances	
			Acquisition		

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There are three ways to add a service to the TAR:

- 1. If you know the code, enter the code in the search field and select **Find Service Category(s)**. This is the preferred method.
- 2. If you don't know the code, but you know the service category, select the appropriate Service Category hyperlink.
- 3. If you don't know the code or the service category, select the **Service Code Search** hyperlink to initiate the search, see the eTAR User Guide: Basics for additional information on code search.
 - **Note:** For Specific Provider Types, refer to the appropriate eTAR User Guides for additional information.

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Apnea Monitor

DME			
			eTAR Medical Tutorials
Please Enter Apnea Informat	ion		
Attachment A Continue			
Service Information			
* Service Code(HCPCS Code)		2 Modifiers (if applicable)	
Service Description (40 characters acc	epted)		
3			
* Total Units	5 Ant. Length of Need		
From Date mmddyyyy	Thru Date mmddyyyy	* Start of Care mmddyyyy	Discharge Date mmddyyyy

- Enter the Service Code being requested if blank. If the service code is unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifier hyperlink to access Code Search.
- 3. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave the field blank.
- 4. Enter the **Total Units** requested. If requesting a rental, enter the number of rental months or days, depending on the service code entered. *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 to select the time period.

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

Ant. Length of Need			
3	1	Month	*

From Date 6 mmddyyyy	Thru Date mmddyyyy	8 * Start of Care mmddyyyy	Discharge Date 9 mmddyyyy
Discharge	~		
Price	Pricing Override Request	V (13)MSRP	
Place of Service	×		
15	if #		

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

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*ICD Code (Decir *ICD-CM Type Required) 16 17	nal Diagnosis Description	18 Date of Onset mmddyyyy
Enter Miscellaneous TAR Informati	on (500 characters accepted)	*
		-

- 16.Use the **ICD-CM Type** drop-down to select the ICD code type.
- 17. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *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.

Note: For retroactive eTARs, make sure the requested From Date and Thru Date are entered.

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Service Continue		
Patient assessment information for this Service (Atta	achment A)	
Please list current medical status codes relevant to req	Diagnosis Description	23 Date Of Onset

- 20. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to requested service(s)** field. If unknown, click the medical status code link to access Code Search.
- 21. Use the **ICD-CM Type** drop-down to select the ICD code type.
- 22. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code hyper link to access Code Search.

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

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

	Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) include dates if applicable. (255 characters accepted)
(24
	If it is known that the patient has ever received the requested or similar service(s), please explain include dates. (255 characters accepted)
(25

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

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Prescribing Physician Information	
* Physician Prescription (255 characters accepted)	
26	
* Physician's License #	28* Physician's Name
* Physician's Phone	30 * Prescription Date
Attachment A Service 31 Continue 32 Another Service, Same Category	

- 26. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 27. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 28. Enter the prescribing Physician's Name. *Required
- 29. Enter the **Physician's Phone** number. *Required
- 30. Enter the Prescription Date (mmddyyyy). *Required
- 31. Click **Continue** to return to the TAR Service menu. See the eTAR Basics User Guide for information on submitting the eTAR.

Or

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

B Allied Health Page updated: September 2020

Augmentative & Alternative Communication (AAC)

Other Services	
	eTAR Medical Tutorials
Please Enter AAC Information	
Attachment A Attachment B Continue	
Service Information	
* Service Code (HCPCS Code)	ers (if applicable)
Service Description (40 characters accepted)	
* Total Units Ant. Length of Need	From Date Thru Date mmddyyyy mmddyyyy

- Enter the Service Code being requested. If the code was entered in the Service Code Search, it will populate automatically. If unknown, click the Service Codes hyperlink, to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifier hyper link to access 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. *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 to select the time period.

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

	Ant. Length of Need	~	
* Total Units Ant. Length of Nee	d	From Date mmddyyyy	Thru Date mmddyyyy
Place of Service	*		
Rendering Provider #			
Pricing Override Request	~	Price	

- 6. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 7. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 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 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.

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* ICD-CM Type	* ICD Code (Decima Required)	I Discosis Description	
*ICD-CM Type	(13) Required)	Diagnosis Description	
Enter Miscellaneou	us TAR Information (500 ch	aracters accepted)	
14			~
			-

- 12. Use the **ICD-CM Type** drop-down 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 hyperlink to access Code Search. *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
* Please list current functional limitation /physical condition codes
* Please list previous functional limitation /physical condition codes
* Please list current medical status codes relevant to requested service(s)

- 15. Use the **P.O.T. Adherence** drop-down to select the level of compliance the patient has to the Plan of Treatment. *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. *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. *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. *Required

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ICD Code ICD-CM Type Required)	(Decimal Diagnosis Description	Date Of Onset
19 20		(21)
Please summarize treatment/proce	dures/surgeries/clinical findings/history relevant to the requested service	e(s) include dates if applicable. (255
22	* *	
* If it is known that the patient has e	ver received the requested or similar service(s), please explain include	dates. (255 characters accepted)
23	<u>,</u>	
Please summarize the therapeutic g	goal to be met with the requested service(s). (255 characters accepted)	
24	×	

- 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 hyperlink to access 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. *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.

Please list alternatives tried or considered and the reason w	vhy they are not feasible for this patient
Service Code 26 Describe Alternativ	e Tried/Considered (30 characters accepted)
25	
Reason	~
Reason	~
Reason	~
Reason	~
Please explain why the least costly method of treatment is r	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 hyperlink to access Code Search. See the eTAR User Guide: Basics 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 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 acc | cepted) |
| (29) | |
| * Physician's License # | * Physician's Name |
| * Physician's Phone | 33* Prescription Date |

- 29.Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 30. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. *Required
- 31. Enter the prescribing Physician's Name. *Required
- 32. Enter the **Physician's Phone** number. *Required
- 33. Enter the **Prescription Date** (mmddyyyy). *Required

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DME Attachment Form (Attachment B)	
* Replacement? 34	
No ○ Yes Yes	
Replacement Reason	Why are you requesting an unlisted procedure code?
35	36
~	~
×	✓
Specific Comments (150 characters accepted)	
37	~
	~
Attachment A Attachment B Service	
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. *Required
- 35. If the circular Replacement radio button is selected as "Yes," use the **Replacement Reason** drop-down 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 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 the eTAR User Guide: Basics for information on submitting the TAR.

Or

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

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Cochlear Implants

Outpatient Services
eTAR Medical Tutorials
Please Enter Cochlear Implant Information
Service Information
* Service Code (HCPCS or CPT Code) Modifiers (if applicable)
Service Description (40 characters accepted)
3)
4 Total Units Side 6 mmddyyyy 7 mmddyyyy
Discharge Date Mmddyyyy Admit Date Mmddyyyy

- Enter the Service Code being requested. If the code was entered in the Service Code Search, it will automatically populate in this field. If unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers hyperlink to access Code Search. *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. *Required
- 5. Use the Side drop-down list to select Right, Left or Bilateral. *Required
- 6. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 7. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.

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- 8. Enter the **Discharge Date** (mmddyyyy). If Discharge has been selected, this field is required.
- 9. Enter the date the patient was or will be admitted in the Admit Date field (mmddyyyy).

Admit From	
Discharge	
* ICD-CM * ICD Code Type (Decimal Required) Diagnosis Description	Date of Onset mmddyyyy
Enter Miscellaneous TAR Information (500 characters accepted)	A
	-
Continue Another Service, Same Ca	tegory

- 10.Use the **Admit From** drop-down to select the level of care from where the patient was admitted.
- 11. Use the **Discharge** drop-down to select the level of care for the patient.
- 12. Enter a **Rendering Provider #** if rendering provider is different from the submitting provider. This will allow another provider to inquire on the eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.
- 13. Use the **ICD-CM Type** drop-down to select the ICD code type. *Required
- 14. Enter secondary **ICD Code**, including the decimal point, indicating the diagnoses relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *Required

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

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		•	
Discharge			
		•	
Rendering Pr	ovider #		
ICD-CM	* ICD Code		
Гуре	(Decimal Required)	Diagnosis Description	15 Date of Onset
-			mmddyyyy
Enter Miscell	aneous TAR Informati	on (500 characters accepted)	
<i>i</i>)			4
_	(17)		2.1

- 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.
- 17.Click **Continue** to return to the TAR Service menu. See the eTAR User Guide: Basics for information on submitting the TAR.

Or

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

DME Beds

DME	
	eTAR Medical Tutorials
Please Enter DME Beds Information	
Attachment A Attachment B Continue	
1 Service Code (HCPCS Code)	2 Modifiers (if applicable)
Service Description (40 characters accepted)	
4 Total Units	6 Ant. Length of Need

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

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

Ant. Length	of	Need	
2	1	Month	*

* From Date	B mmddyyyy	9 * Start of Care mmddyyyy	Discharge Date mmddyyyy
Admit From	~		
Discharge	~		
* Place Of Service	v		
Rendering Provider #			

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

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(15	Pricing Override Request	•	16 Price	17 MSRP	
(18	* ICD-CM * ICD Code (Decimal Type Required)	Diagnosis De	escription	20 Date of Onset mmddyyyy	
21	Enter Miscellaneous TAR Information (5	00 characters acce	epted)	~	
				Ŧ	

- 15. Use the **Pricing Override Request** drop-down to select an override code for unlisted items or prices.
- 16. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
- 17. Enter the **MSRP** (Manufacturer's Suggested Retail Price) or actual invoice price for the service being requested, up to seven digits.
- 18. Use the ICD-CM Type drop-down to select the ICD code type. *Required
- 19. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *Required

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

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

Attachment B Service Continue		
Patient assessment information for this Service (Attachment A)		
P.O.T. Adherence	Feeding Method	
In-Home Assistance/Care Giver	25	26 Weight Ibs. OZ.

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

Please list current functional limitation /physical condition codes	
Please list previous functional limitation /physical condition codes	
Please list current medical status codes relevant to requested service(s)	
29	

- 27. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search.
- 28. 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.
- 29. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code hyperlink to access Code Search.

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30 Diagnosis Description Date of Onset	
Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) include dates if applicable. (255 characters accepted)	
33)	
· · ·	
If it is known that the patient has ever received the requested or similar service(s), please explain include dates (255 characters accepted)	
(34) ^	
· · · · · · · · · · · · · · · · · · ·	
Please summarize the therapeutic goal to be met with the requested service(s). (255 characters accepted)	
(35)	
v	

- 30. Use the **ICD-CM Type** drop-down to select the ICD code type.
- 31. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code hyperlink to access Code Search.

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

- 32 Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
- 33. Enter a summary of the treatment and history of the patient in the **Please summarize** treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable field.
- 34. Enter information regarding any similar services in the **If it is known that the patient** has ever received the requested or similar service(s), please explain include dates field.
- 35. Enter a summary of the therapeutic goal to be met in the **Please summarize the therapeutic goal to be met with the requested service(s)** field.

Service Code	37	tive Tried/Considered (30 characters accepted)
	Reason	▼ 38
	Reason	▼
	Reason	✓
	Reason	~
Please explain why the least costly m	ethod of treatment is not being used. (255 cha	racters accepted)

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

Prescribing Physician Information	
* Physician Prescription (255 characters accepted)	
40	
* Physician's License #	* Physician's Name
	42
* Physician's Phone	* Prescription Date
	(44)

- 40. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 41. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 42. Enter the prescribing Physician's Name. *Required
- 43. Enter the Physician's Phone number. *Required
- 44. Enter the Prescription Date (mmddyyyy). *Required

Attachment A Service	Continue	
DME Attachment Form (A	ttachment B)	
Unlisted Reason		Ideal Weight
	~	46
	~	
Home Accessible?	Safe Operation?	Independent Operation?
47 No O Yes	48 No Ves	(49) No () Yes

- 45. If the service requested is for an unlisted code, use the **Unlisted Reason** drop-down to select up to three reasons why a listed code cannot be used in place of the unlisted code.
- 46. Enter the patient's **Ideal Weight** in pounds.
- 47. Click the circular **Home Accessible**? radio button to indicate if the patient's home is accessible for the Equipment.
- 48. Click the circular **Safe Operation**? radio button to indicate if the patient is able to operate the equipment requested safely.
- 49. Click the circular **Independent Operation**? radio button to indicate if the patient is able to operate the equipment requested independently.



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

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* Lab Date	Hemoglobin	Hematocrit	Albumin
mmddyyyy			
Serial #	Manufacturer		Model
59	60		61
Purchase Date	Purchased By		Warr. Exp. Date
62 mmddyyyy	63	~	64 mmddyyyy
Attachment A	Attachment B Service		
	65 Continue	Another Service, Same	Category

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

Or

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

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Hearing Aids

DME	
	eTAR Medical Tutorials
Please Enter Hearing Aid Ir	nformation
Attachment A Attachment C Cor	ntinue
Service Information	
* Service Code (HCPCS Code)	Modifiers (if applicable)
Service Description (40 characters accepted)	
3	
	Rendering
* Side Total Units	Provider #

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

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From Date 7 mddyyyy	Thru Date 8 mmddyyyy	
Pricing Override Request	Price	
* ICD Code (Decimal * ICD-CM Type Required) 11 12 12	Diagnosis Description	13 Date of Onset mmddyyyy
Enter Miscellaneous TAR Information (500 characters accepted)	
14		*
		-

- 7. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 8. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 9. Use **the Pricing Override Request** drop-down to select an override code for unlisted items or prices.
- 10. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
- 11. Use the ICD-CM Type drop-down to select the ICD code type.
- 12. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code hyperlink to access Code Search.

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

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

Attachment C Service Continue]	
Patient assessment information for this	Service (Attachment A)	
Please list current functional limitation /p	physical condition codes	
Please list previous functional limitation	/physical condition codes	
16		
Please list current medical status codes r	relevant to requested service(s)	
ICD-CM ICD Code (Decimal		
Type Required)	Diagnosis Description	Date Of Onset
(18) (19)		(20)

- 15. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search.
- 16. Enter the previous functional limitation or physical condition relative to the requested services in the **Please list previous functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. See the eTAR Basics User Guide for more information on Code Search.
- 17. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code hyperlink to access Code Search.
- 18.Use the **ICD-CM Type** drop-down to select the ICD code type.
- 19. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code link to access Code Search.

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

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

Service Code	Describe Alternative Tried/Considered (30 characters accepted)
21	(22)
Dagaa	23
Reason	
Reason	·
Reason	· ·
Reason	
Please summarize treatment/procedure service(s) include dates if applicable	s/surgeries/clinical findings/history relevant to the requested (255 characters accepted)
24	·
	~
include dates. (255 characters accepted	ed)
25	~
	~

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

Prescribing Physician Information	
* Physician Prescription (255 characters accepted)	
26 * Physician's License # 27 * Physician's Phone	* Physician's Name
	30 rescription bale

- 26.Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required.
- 27. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 28. Enter the prescribing Physician's Name. *Required
- 29. Enter the Physician's Phone number. *Required
- 30. Enter the **Prescription Date** (mmddyyyy). *Required

Attachment A Service Continue		
Audiologic Attachment Form (Attac	hment C)	
* Examiner/Provider	Altern. Test	* Exam Date
*Exam Location	~	

- 31. Enter the Provider number of the Examiner/Provider. *Required
- 32 Click the **Altern. Test** checkbox to indicate if an alternate test was performed due to the patient not speaking English. If this field is selected, the alternate test method and results are required in the remarks field.
- 33. Enter the Exam Date (mmddyyyy). *Required
- 34. Use the **Exam Location** drop-down list to select the place of service in which the exam was performed. *Required

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

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



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

Hearing Aid Replacemen	nt/Repair Information		
Left Side			
Service Code	Replace?	Replace Rsn.	
47	No Ves	49	~
	Repair?	Repair Rsn.	
	(50) ● No ○ Yes	51	
Serial #	Model		
52			
Manufacturer			
		Warranty	
Purchase Date	Purchased By	Expiration Date	
	~		

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

Hearing Aid Replace	ement/Repair Information	
Left Side		
Service Code	Replace?	Replace Rsn.
	No O Yes	×
	Repair?	Repair Rsn.
	No O Yes	×
Serial #	Model	
	53	
Manufacturer		
54		
		Warranty
Purchase Date	Purchased By	Expiration Date
55	56	(57)

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

Incontinence Supplies

DME			
			eTAR Medical Tutorials
Please Enter Incontinence Supply In	formation		
Attachment A Attachment D Continue			
Service Information		Martifican (Kanaliashia)	
Service Code (HCPCS Code or Medical Supply Code)			
Service Description (40 characters accepted)			* Total Units
3]		(4)
* Quantity	* Frequency		Ant. Length of Need

- 1. Enter the **Service Code** to identify the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifier link to access 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. *Required
- 5. Enter the **Quantity** for the number of units to be used per time period. Enter the number of units in the first field and use the drop-down list to select the time period.

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

* Quantity			
200	1	Month	*

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* Quantity	6 / /	Ant. Length of Need
From Date 8 nddyyyy	9 mmddyyyy	Provider #
Pricing Override Request	~	Price
* Place of Service	×	

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

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

* Frequency	Y	
10	/ Day	~

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

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

Ant. Length	of	Need
1	 	Lifetime 💌

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

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Pricing Override Request	12 Price
* Place of Service	
*ICD Code (Decimal *ICD-CM Type Required) 15 Diagnosis Description	16 Date of Onset mmddyyyy
Enter Miscellaneous TAR Information (500 characters accepted)	A
	~

- 11. Use the **Pricing Override Request** drop-down to select an override code for unlisted items or prices.
- 12. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
- 13.Use **Place of Service** the drop-down to select the location where the service is being rendered. *Required
- 14. Use the **ICD-CM Type** drop-down to select the ICD code type. *Required
- 15. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *Required

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

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

Attachment D Service Continue	
Patient assessment information for this Service (Attachment A)	
Height	Weight 19 Ibs. oz.
Please list current functional limitation /physical condition codes	
Please list previous functional limitation /physical condition codes	
Please list current medical status codes relevant to requested service(s)	

- 18. Enter the patient's Height in feet and inches.
- 19. Enter the patient's **Weight** in pounds and ounces.
- 20. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search.
- 21. Enter the previous functional limitation or physical condition relative to the requested services in the **Please list previous functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search.
- 22. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code link to access Code Search.

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ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
23 🔻	24		25
•			
•			
Please summarize	e treatment/procedures/surg	geries/clinical findings/history relevant to the requested s	ervice(s) (include dates if applicable) (255
26	ed)		
			A
			*
			*
If it is known that t	the patient has ever receive	d the requested or similar service(s), please explain (inc	lude dates) (255 characters accepted)
If it is known that t	the patient has ever receive	d the requested or similar service(s), please explain (inc	vulue dates) (255 characters accepted)
If it is known that 1	the patient has ever receive	d the requested or similar service(s), please explain (inc	v lude dates) (255 characters accepted)
If it is known that to 27	the patient has ever receive	d the requested or similar service(s), please explain (inc	v lude dates) (255 characters accepted)
If it is known that 1 27 Please summarize	the patient has ever receive e the therapeutic goal to be	d the requested or similar service(s), please explain (inc met with the requested service(s) (255 characters accep	<pre>vulue dates) (255 characters accepted) vulue dates) (255 characters accepted) vulue dates) (255 characters accepted)</pre>

- 23. Use the **ICD-CM Type** drop-down to select the ICD code type.
- 24. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search.

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.

	30	
	Reason	(31)
	Reason	
	Reason	
	Reason	
se explain why the least costly r	nethod of treatment is not being used. (255 charac	cters accepted)

- 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 hyperlink to access 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 to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
- 32. Enter a summary of the treatment and history of the patient in the **Please summarize** treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable field.

Attachment A Service Continue	
Incontinence Attachment Form (Attachment D)	
Incontinence Supply Information	
Please describe prognosis for controlling incontinence (255 characters accepted)	
33	
Please summarize treatment plan (255 characters accepted)	
Please document need for multiple products (255 characters accepted)	

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



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

TAR Required?	Service Code	Daily Usage	Unit Cost	Monthly Usage	Monthly Cost	Total Units Total Cost
💿 No 🔘 Yes						
💿 No 🔘 Yes						
💿 No 🔘 Yes						
💿 No 🔘 Yes						
💿 No 🔘 Yes						
No ○ Yes Yes						

- 44. Use the **# of Months Prescription Valid** drop-down to select the duration of the prescription in months. *Required
- 45. Click the circular **Generic Equivalents Prescribed?** radio button to indicate if the physician prescribed generic equivalent products. *Required

Prescribing Physician Information * Physician's License # 46 * Physician's Phone 48	* Physician's Name 47 * Prescription Date 49
Attachment A Attachment D Service	50 Continue Another Service, Same Category

- 46. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 47. Enter the prescribing Physician's Name. *Required
- 48. Enter the Physician's Phone number. *Required
- 49. Enter the Prescription Date (mmddyyyy). *Required
- 50. Click **Continue** to return to the TAR Services menu. See the eTAR User Guide: Basics for information on submitting the eTAR.

Or

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

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IV Equipment

DME				
		eTAR Medical T	utorials	
Please Enter DME IV Equipment Information				
Attachment A Continue]			
Service Information				
Service Code (HCPCS Code) Modifiers (if applicable)				
Service Description (40 characters accepted)				
* Total Units Sched.		* Frequency		
	~	· /	~	
Ant. Length of Need * Fr	om Date	Thru Date	* Start of Care	
/ m	mddyyyy	mmddyyyy	mmddyyyy	

- 1. Enter the **Service Code** to identify the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifier hyper link to access 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 Unit**s requested. If requesting a rental, enter the number of rental months or days, depending on the service code entered. *Required
- 5. Use the **Sched**. drop-down list to select the appropriate details for the requested service. If "Other" is selected, enter the schedule in the Miscellaneous TAR Information field.

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DME	
	eTAR Medical Tutorials
Please Enter DME IV Equipme	ent Information
Attachment A Continue	
Service Information	
* Service Code (HCPCS Code)	Modifiers (if applicable)
Service Description (40 characters accepted)	
* Total Units Sched.	* Frequency
Ant. Length of Need * From Date	Thru Date * Start of Care
/ B mmddyyyy	mmddyyyy mmddyyyy

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

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

* Frequency		
2	/ Day	*

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

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

Ant. Length of Need			
1	/ Month	~	

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

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Ant. Length of Need	* From Date mmddyyyy	Thru Date mmddyyyy	* Start of Care 10 mmddyyyy
Pricing Override Request		Price	
* Place of Service 13 Rendering Provider # 14			
*ICD-CM Type Tequired)	Diagnosis Description		Date of Onset mmddyyyy
Enter Miscellaneous TAR Information (500 c	haracters accepted)	×	

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

Note: The Diagnosis Description field is no longer in use. Leave this field blank.
Ant. Length of Need	* From Date	Thru Date	* Start of Care
	mmddyyyy	mmddyyyy	mmddyyyy
Pricing Override Request		Price	
	•		
* Place of Service			
	•		
Rendering Provider #			
*ICD-CM Type Required)	Discossis Description		Date of Opent
			17 mmddianau
Enter Miscellaneous TAR Information (500) characters accepted)		
18		*	
		-	

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

Service Continue		
Patient assessment informa	ation for this Service (Attachment A)	
Please list current functional	limitation /physical condition codes	
19		
Please list current medical st	tatus codes relevant to requested service(s)	
20		
ICD Co	de (Decimal	
ICD-CM Type Require	d) Diagnosis Description	Date Of Onset
21 22		(23)

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

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

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

Please summarize treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) include dates if applicable. (255 characters accepted)	
(24)	~
If it is known that the patient has ever received the requested or similar service(s), please explain	
25	~ ~
Please summarize the therapeutic goal to be met with the requested service(s). (255 characters accepted)	
26	^

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

Please list alternatives tried or considered and the reason why they Service Code 27 28	are not feasible for this patient Describe Alternative Tried/Considered (30 characters accepted)
Reason	29
Reason	
Reason	
Reason	
Please explain why the least costly method of treatment is not being	used. (255 characters accepted)

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

Prescribing Physician Information	
* Physician Prescription (255 characters accepted)	
31	
* Physician's License #	33 Physician's Name
* Physician's Phone	35 * Prescription Date
Attachment A Service	36 Continue Another Service, Same Category

- 31. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 32. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 33. Enter the prescribing Physician's Name. *Required
- 34 Enter the Physician's Phone number. *Required
- 35 Enter the **Prescription Date** (mmddyyyy). *Required
- 36. Click **Continue** to return to the TAR Services menu. See the eTAR User Guide: Basics for information on submitting the eTAR.

Or

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

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Medical Supply

DME					
		eTAR Mee	dical Tutorials		
Please Enter DME Medical Supply Information					
Attachment A Continue					
Service Information					
* Service Code (HCPCS or Medical	Supply				
Code)	Modif	ers (if applicable))		
	2				
Service Description (40 characters a	accepted)				
3					
* Total Units Quar	ntity		Frequency		
45_	1	~	/	*	
Ant. Length of Need	From Date	Thru Date	Start of Care		
/	mmddyyyy	mmddyyyy	mmddyyyy		

- 1. Enter the **Service Code** to identify the service being requested. If the code was entered in the Service Code Search, it will automatically populate. If unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required.
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifier hyperlink to access 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. *Required
- 5. Enter the **Quantity** for the number of units to be used per time period. Enter the number of units in the first field and use the drop-down to select the time period.

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

Quantity		
2	/ Month	~

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DME	
	eTAR Medical Tutorials
Please Ent	er DME Medical Supply Information
Attachment A	Continue
Service Information	
* Service Code (HCP Code)	CS or Medical Supply Modifiers (if applicable)
Service Description (4	characters accepted)
* Total Units	Quantity Frequency
Ant. Length of Need	From Date Thru Date Start of Care mmddyyyy mmddyyyy mmddyyyy

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

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

Frequency		
3	/ Day	~

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

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

Ant. Length of Need				
6 / Month 🖌				

- 8. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 9. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive.

Ant. Length of Need	From Date	Thru Date	Start of Care
	mmddyyyy		mmddyyyy
11	•	(12) 100]
* Place of Service	•		
Rendering Provider #			
*ICD Code (Decimal *ICD-CM Type Required)	Diagnosis Description		Date of Onset
			mmddyyyy
Enter Miscellaneous TAR Information	(500 characters accepted)		
			*
			.

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

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Ant. Length of Need	From Date	Thru Date	Start of Care
/	mmddyyyy	mmddyyyy	mmddyyyy
Price Override		Price	
	•		
* Place of Service			
	-		
Rendering Provider #			
*ICD Code (Decimal			
*ICD-CM Type Required) Diag	nosis Description		Date of Onset
Enter Miscellaneous TAR Information (500 c	haracters accepted)		
18			*
			~

16. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *Required

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

Service Continue	
Patient assessment information for this Servic	e (Attachment A)
P.O.T. Adherence	In-Home Assistance/Care Giver
19	20 Hrs/Day Days/Wk
Please list current functional limitation /physical co	ndition codes
Please list previous functional limitation /physical c	condition codes
Please list current medical status codes relevant to	requested service(s)

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

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ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
24 🗸	(25)		26
•			
•			
Please summa applicable. (25	arize treatment/proced 5 characters accepte	dures/surgeries/clinical findings/history relevant to the requested d)	service(s) include dates if
(27)			*
If it is known ti accepted)	nat the patient has evo	er received the requested or similar service(s), please explain	include dates. (255 characters
28			<u> </u>
			T
Please summa	arize the therapeutic g	oal to be met with the requested service(s). (255 characters acc	epted)
29			*
			*

- 24. Use the **ICD-CM Type** drop-down to select the ICD code type.
- 25. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code hyperlink to access Code Search.

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

)	31	
	Reason	32
	Reason	V
	Reason	▼
	Reason	∨
lease explain why the least cost!	Reason y method of treatment is not being used. (25	5 characters accepted)

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

Prescribing Physician Information	
* Physician Prescription (255 characters ad	ccepted)
34)	
* Physician's License #	* Physician's Name
* Physician's Phone	* Prescription Date
Attachment A Service	39 Continue Another Service, Same Category

- 34. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. This replaces the need for submitting this information as an attachment. *Required
- 35 Enter the National Provider Identifier (NPI) in the **Physician's License #** field. *Required
- 36. Enter the prescribing Physician's Name. *Required
- 37 Enter the Physician's Phone number. *Required
- 38. Enter the Prescription Date (mmddyyyy). *Required
- 39. Click **Continue** to return to the TAR Service menu. See the eTAR User Guide: Basics for information on submitting the eTAR.

Or

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

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Orthotics/Prosthetics

DNIE	
	eTAR Medical Tutorials
Please Enter Orthotics/	Prosthetics Information
Attachment A Attachment	t B Continue
Service Information	
Service Code (HCPCS Code)	Modifiers (if applicable)
1	2
Service Description (40 characters	accepted) * Side
3	4
* Total Units Quantity	Frequency

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

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

Quantity			
4	1	Month	*

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* Total Units	Quantity		Frequency
Ant. Length of Need		9 From Date 9 mmddyyyy	10 Thru Date mmddyyyy
Place Of Service	~		
Rendering Provider #			

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

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

Frequency		
5	/ Day	*

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

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

2 / Month 💙	Ant. Ler	ng	th of Need	
- /	2	1	Month	~

- 9. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 10. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range of dates during which service will be provided.
- 11. Use **Place of Service** the drop-down list to select the location where the service is being rendered.
- 12. Enter a **Rendering Provider #** if rendering provider is different from submitting provider. This will allow another provider to inquire on eTAR service information. If the submitting and rendering provider numbers are the same, leave the field blank.

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Pricing Override Request		Price
13	•	14
* IC	D Code (Decimal	
*ICD-CM Type Rec	uired) Diagnosis Description	Date of Onset
15 16		(17) mmddyyyy
Enter Miscellaneous TAR In	formation (500 characters accepted)	
(18)		A
		-

- 13. Use the **Pricing Override Request** drop-down list to select an override code for unlisted items or prices.
- 14. Enter the **Price** requested including a decimal point for unlisted items or price, up to seven digits. If Pricing Override Request is selected, this field is required.
- 15. Use the **ICD-CM Type** drop-down list to select the ICD code type.
- 16. Enter the ICD Code, including the decimal point, indicating the primary diagnosis relevant to the requested service. If unknown, click the ICD Code link to access Code Search.

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

Attachment B Service Continue
Patient assessment information for this Service (Attachment A)
* P.O.T. Adherence Height Weight 19 20
* Please list current functional limitation /physical condition codes 22
* Please list previous functional limitation /physical condition codes 23
* Please list current medical status codes relevant to requested service(s)

- 19. Use the **P.O.T Adherence** drop-down list to select the level of compliance the patient has to the Plan of Treatment. *Required
- 20. Enter the patient's Height in feet and inches.
- 21. Enter the patient's Weight in pounds and ounces.
- 22. Enter the current functional limitation or physical condition relative to the requested services in the **Please list current functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. *Required
- 23. Enter the previous functional limitation or physical condition relative to the requested services in the **Please list previous functional limitation/physical condition codes** field. If unknown, click the functional limitation link to access Code Search. *Required
- 24. Enter current medical status codes which describe the patient's condition in the **Please list current medical status codes relevant to the requested service(s)** field. If unknown, click the medical status code link to access Code Search. *Required

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ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	Date Of Onset
•			
Please summarize trea characters accepted)	tment/procedures/surgeries/clinical findir	ngs/history relevant to the requested servi	ice(s) include dates if applicable. (255
28)		* *	
* If it is known that the	patient has ever received the requested of	or similar service(s), please explain incl	ude dates. (255 characters accepted)
29)		*	
Please summarize the	therapeutic goal to be met with the reque	sted service(s). (255 characters accepted	d)
30		*	

- 25. Use the **ICD-CM Type** drop-down list to select the ICD code type.
- 26. Enter the secondary **ICD Code**, including the decimal point, indicating the diagnoses relevant to the requested service. If unknown, click the ICD Code link to access Code Search.

- 27. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
- 28. Enter a summary of the treatment and history of the patient in the **Please summarize** treatment/procedures/surgeries/clinical findings/history relevant to the requested service(s) – include dates if applicable field.
- 29. Enter information regarding any similar services in the **If it is known that the patient** has ever received the requested or similar service(s), please explain – include dates field. *Required
- 30. Enter a summary of the therapeutic goal to be met in the **Please summarize the therapeutic goal to be met with the requested service(s)** field.

rvice Code	Describe Alt	ernative Tried/Considered (30 characters accepted)
	(32)	
	Reason	✓ (33)
	Reason	~
	Reason	~
	Reason	~
ase explain why the least costly	method of treatment is not being used. (255	characters accepted)
		~

- 31. Enter the **Service Code** 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.
- 32. Enter details in the **Describe Alternative Tried/Considered** field. If an alternative service code has been entered in the adjacent field, leave the field blank.
- 33. Use the **Reason** drop-down list to identify why the service is not feasible for this patient. If a corresponding alternative service code or description is not entered, leave the field blank.
- 34. Enter a brief explanation in the Please explain why the least costly method of treatment is not being used field.

Prescribing Physician Information	
* Physician Prescription (255 characters accepted)	
35	
* Physician's License #	* Physician's Name
* Physician's Phone	* Prescription Date

- 35. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 36. Enter the National Provider Identifier (NPI) in the **Physician's License #** field. *Required
- 37 Enter the prescribing Physician's Name. *Required
- 38. Enter the Physician's Phone number. *Required
- 39. Enter the Prescription Date (mmddyyyy). *Required

Attachment A Service Continue			
DME Attachment Form (Attachment B)			
* Replacement?			
₩ No O Yes			
Replacement Reason	Unlisted Reason		
41	(42)	~	
~		~	
*		~	
Home Accessible? B No O Yes Specific Comments (150 characters accepted)		
44)			1000

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

Or

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

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Respiratory Care

Other Services	
	eTAR Medical Tutorials
Please Enter Respiratory Therapy Info	rmation
Attachment A Continue	
Service Information	
* Service Code (HCPCS or CPT Code)	odifiers (if applicable)
Service Description (40 characters accepted)	_
3	
* Total Units * Quantity	* Frequency
	/

- 1. Enter the **Service Code** being requested if blank. If the service code is unknown, click the Service Codes hyperlink, to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers hyperlink to access 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. *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 to select the time period. *Required

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

* Quantity		
2	/ Month	*

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* Total Units	* Quantity	* Frequency	
			*
* Schedule		Ant. Length of Need	
* From Date		* Thru Date	
mmddyyyy		10 mmddyyyy	
* Start of Care		Discharge Date 12 mmddyyyy	

 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 to select the time period.
 *Required

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



- Use the Schedule drop-down to select the details for the requested service. If the schedule selected is Other, enter the schedule in the Enter Miscellaneous TAR Information field. *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 to select the time period.

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

Ant. Length of Need			
2	1	Month	~

- 9. Enter the **From Date** (mmddyyyy) for the requested start of service date. If request is planned, enter range of dates during which service will be provided. *Required
- 10. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. If request is planned, enter range of dates during which service will be provided. *Required
- 11. Enter the **Start of Care** date (mmddyyyy) the patient will begin, or has begun, receiving the requested service. *Required
- 12. Enter the **Discharge Date** (mmddyyyy) the patient completed receiving the requested services. *Required

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Discharge			
13	•		
* Place of Service			
14			
Rendering Provider #			
15			
* ICD Code (Decimal			
16 (17)	Diagnosis Description		18 Date of Onset
			mmddyyyy
Enter Miscellaneous TAR Information (500 c	haracters accepted)		
(19)		A	
		~	
*			

- 13. Use the **Discharge** drop-down to select the level of care for the patient.
- 14. Use the **Place of Service** drop-down to select the location where the service is being rendered. *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 to select the ICD code type. *Required
- 17. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *Required

- 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 Continue
Patient assessment information for this Service (Attachment A)
20
Height 22 Weight 02.
* Please list current functional limitation/physical condition codes
Please list previous functional limitation/physical condition codes
* Please list current medical status codes relevant to requested service(s)

- 20. Use the **P.O.T. Adherence** drop-down 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. *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. *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. *Required

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ICD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	28 Date Of Onset
26	(21)		
•			
Please summariz characters accept	e treatment/procedures/surgeri ted)	es/clinical findings/history relevant to the requested	service(s) include dates if applicable. (255
29			~ ~
* Please summar	ize the therapeutic goal to be m	net with the requested service(s). (255 characters ac	cepted)
(30)			* *

- 26. Use the **ICD-CM Type** drop-down 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 hyperlink to access Code Search.

- 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) *Required

* Please list alternatives tried or conside	ered and the reason why they are not feasible for this patient
* Service Code	* Describe Alternative Tried/Considered (30 characters accepted)
31	32
* Reason	
Reasor	
Reasor	
Reasor	
* Please explain why the least costly m	ethod 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 hyperlink to access Code Search. *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. *Required
- 33. Use the **Reason** drop-down 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. *Required
- 34. Enter a brief explanation in the Please explain why the least costly method of treatment is not being used field. *Required

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Prescribing Physician Information	
* Physician Prescription (255 characters accepted)	
(35)	~
* Physician's License # * Physician's Name	
(36) (37)	
* Physician's Phone 38 () - - * Prescription Date 39	
Attachment A Service	
40 Continue Another Service, Same Category	

- 35. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 36. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 37. Enter the prescribing Physician's Name. *Required
- 38. Enter the Physician's Phone number. *Required
- 39. Enter the Prescription Date (mmddyyyy). *Required
- 40. Click **Continue** to return to the TAR Service Menu. See the eTAR Basics User Guide for information on submitting the TAR.

Or

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

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Speech/Occupational/Physical Therapy

Other Services	
	eTAR Medical Tutorials
Please Enter Speech/Occup	ational/Physical Therapy Information
Attachment A Continue	
ervice Information	
Service Code (HCPCS or CPT Code)	Modifiers (if applicable)
1)	2
ervice Description (40 characters accepted	d)
3)	
ide * Total Units *	Frequency * Ant. Length of Need

- 42. Enter the **Service Code** being requested if blank. If the service code is unknown, click the Service Codes link, to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 43. Enter up to four **Modifiers**, if applicable. If unknown, click the Modifiers link to access Code Search.
- 44. Enter the **Service Description** if an unlisted, generic, or miscellaneous service code is used. Otherwise, leave this field blank.
- 45. Use the **Side** drop-down list to select Right, Left or Bilateral.
- 46. Enter the Total Units requested. *Required
- 47. 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. *Required

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

* Frequer	nc	у	
1	1	Week	*

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Side	* Total Units	* Frequency	* Ant. Length of Need
From Date 8 mmddyyyy	Thru Date 9 mmddyyyy	Start of Care 10 mmddyyyy	Discharge Date 11 mmddyyyy
Discharge		~	
Rendering Provider #			
* POS		*	

48. 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. *Required

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

*Ant. Leng	gth	n of Need	
2	1	Month	~

- 49. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range if dates during which service will be provided.
- 50. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range if dates during which service will be provided.
- 51. Enter the **Start of Care** (mmddyyyy) date the patient began, or will begin, receiving the service requested.
- 52. Enter the **Discharge Date** (mmddyyyy) the patient completed receiving the requested services. * Required
- 53. Use the **Discharge** drop-down list to select the level of care for the patient.
- 54. 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.
- 55. Use the **POS** drop-down list to select the location where the service is being rendered. *Required

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* ICD Code (Decimal * ICD-CM Type Required) D 15 16	Diagnosis Description]	17 Date of Onset mmddyyyy
Enter Miscellaneous TAR Information (500	characters accepted)		
18		*	
		-	

- 56. Use the **ICD-CM Type** drop-down list to select the ICD code type. *Required
- 57. 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. *Required

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

P.O.T. Adherence	Feeding Method
* In-Home Assistance/Care Giver 21 Hrs/Day Days/Wk	Height Weight 23 Ibs. oz.
* Please list current functional limitation/physical condition co	odes
Please list previous functional limitation/physical condition co	bdes
Please list current medical status codes relevant to requester	d service(s)

- 60. Use the **P.O.T. Adherence** drop-down list to select the level of compliance the patient has to the Plan of Treatment.
- 61. Use the **Feeding Method** drop-down list to select the method by which the patient is fed.
- 62. 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. *Required
- 63. Enter the patient's Height in feet and inches.
- 64. Enter the patient's Weight in pounds and ounces.
- 65. 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. *Required
- 66. 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.

CD-CM Type	ICD Code (Decimal Required)	Diagnosis Description	* Date Of Onset	
\mathcal{D}	28		29	
~				
lease summa	rize treatment/procedure:	s/surgeries/clinical findings/history relevan	t to the requested service(s) include dates if a	opplicable. (255
aracters accep	10001			
aracters accep			*	
)			*	
it is known th	at the patient has ever re	sceived the requested or similar service(s), please explain include dates, (255 charact	ers accepted)
it is known th	at the patient has ever re	sceived the requested or similar service(s), please explain include dates. (255 charact	ters accepted)

- 67. 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.
- 68. Use the **ICD-CM Type** drop-down list to select the ICD code type.
- 69. 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.

- 70. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field.
- 71. 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. *Required
- 72. 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. *Required

* Please summarize the therapeutic goal	to be met with the requested service(s). (255 characters accepted)
32	
Please list alternatives tried or considered	d and the reason why they are not feasible for this patient
* Service Code	* Describe Alternative Tried/Considered (30 characters accepted)
	34
* Reason	35
Reason	~
Reason	~

- 73. 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. *Required
- 74. 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. *Required
- 75. 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. *Required
- 76. 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. *Required

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Prescribing Physician Information	
* Physician Prescription (255 characters accepted)	
	~ ~
* Physician's License # * Physician's Name	
* Physician's Phone 39 ()	
Attachment A Service	
41 Continue Another Service, Same Category	

- 77. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 78. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 79. Enter the prescribing Physician's Name. *Required
- 80. Enter the **Physician's Phone** number *Required
- 81. Enter the **Prescription Date** (mmddyyyy). *Required
- 82. Click **Continue** to return to the TAR Service Menu. See the eTAR User Guide: Basics for information on submitting the TAR.

Or

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

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Transportation

Other Servi	ices	
		eTAR Medical Tutorials
Please Enter	Transportation I	nformation
Attachment A	Continue	
Service Information	I.	
Rendering Provider #		
* From Date 2 mmddyyyy	* Thru Date 3 mmddyyyy	* 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. If request is planned, enter range if dates during which service will be provided. *Required
- 3. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. If request is planned, enter range if dates during which service will be provided. *Required
- 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 to select the time period.
 *Required

Example: If three trips per week is needed, enter:

* Frequer	nc	у	
3	1	Week	~

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. *Required
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Appointment Information
* Appointment With (55 characters accepted) Time (24HR) Contact Phone 7 8 () -
Primary Care Information
* Physician's Name (25 characters accepted) Phone 9 () -
Origin Information
* Origin
* Street Address (25 characters accepted)
* City * State * Zip Code (1) (14) (15) (14) (15)

- 6. Enter the name of the provider, physician or medical group in the **Appointment With** field.*Required
- 7. Enter the appointment **Time** in a 24-hour format. Example: For 9 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. *Required
- 10. Enter the **Phone** number of the primary care physician.
- 11.Use the **Origin** drop-down to select the place of service where the transport begins. *Required.
- 12. Enter the Street Address of the origin. *Required

Note: Do not use a P.O. Box for the Street Address. Only use a physical address.

- 13. Enter the **City** of origin. *Required
- 14. Use the State drop-down to select the state of origin. *Required
- 15. Enter the Zip Code of origin. *Required

Destination Information	
* Primary Destination	
(16)	~
* Street Address (25 characters acc	cepted)
(17)	
* City	* State * Zip Code *Miles One Way
18	19 20 21
Second Destination Street Address (25 characters acce	epted)
City	State Zip Code Miles One Way
Return Miles	

- 16.Use the **Primary Destination** drop-down to select the place of service where the patient is traveling. *Required
- 17. Enter the Street Address of the primary destination. *Required
- 18. Enter the City of the primary destination. *Required
- 19. Use the State drop-down to select the state of the primary destination. *Required
- 20. Enter the **Zip Code** of the primary destination. *Required
- 21. Enter the number of **Miles One Way** from the origin address to the primary destination address. *Required

Destination Information	
* Primary Destination	
	~
* Street Address (25 characters acc	epted)
	25 26 27
* City	* State * Zip Code *Miles One Way
(24)	
Second Destination	~
Street Address (25 characters acce	pted)
City	State Zip Code Miles One Way
Return Miles	
28	

- 22. For three-way trips, use the **Second Destination** drop-down select the place of service where the patient is traveling as a second destination. *Required only for three-way trips.
- 23. Enter the **Street Address** of the secondary destination. *Required only for three-way trips.
- 24. Enter the **City** of the secondary destination. *Required only for three-way trips.
- 25.Use the **State** drop-down select the state of the secondary destination. *Required only for three-way trips.
- 26. Enter the **Zip Code** of the secondary destination. *Required only for three-way trips.
- 27. Enter the number of **Miles One Way** from the primary destination address to the secondary destination address. *Required only for three-way trips.
- 28. Enter the **Return Miles** between the secondary destination and the origin. *Required only for three-way trips.

	Address (25 characters ac	cepted)			
City		State Zip	Code Miles	One Way	
Peturn	Miae				
teturn	mies				
ranspor	tation service codes & Total Unit	5			
Code	Modifiers (if applicable)	" Units	Code	Modifiers (if applicable)	Units
9	30	31)			
Code	Modifiers (if applicable)	Units	Code	Modifiers (if applicable)	Units
Code	Modifiers (if applicable)	Units	Code	Modifiers (if applicable)	Units
Foter	Viscellaneous TAR Inform	nation (500 charad	cters accente	d)	

- 29. Enter the service **Code** to identify the service being requested. At least one code must be entered. *Required
- 30. Enter up to four **Modifiers**, if applicable. Providers may need to include details related to the services in the Enter **Miscellaneous TAR Information** field.
 - **Note:** Providers are able to include up to four modifiers (if applicable) per service code on their *Treatment Authorization Request* (TAR) and claim. For dates of service on or after November 1, 2018, claims submitted for an NEMT service that includes modifiers must have an approved TAR with matching modifiers. Claims that include modifiers that are not supported by the TAR will be denied.
- 31. Enter the total number of **Units** requested. This field must be completed for each code that is entered. *Required.
- 32. Enter **Miscellaneous TAR Information** with additional details and medical justification pertinent to the requested service.

Service Continue	
Patient assessment information for this Se	ervice (Attachment A)
P.O.T. Adherence	In-Home Assistance/Care Giver
	34 Hrs/Day Days/Wk
Height Weight	oz.
* Please list current functional limitation/physical of	condition codes
Please list previous functional limitation/physical of 38	condition codes
* Please list current medical status codes relevan	t to requested service(s)

- 33. Use the **P.O.T. Adherence** drop-down to select the level of compliance the patient has to the Plan of Treatment.
- 34. 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.
- 35. Enter the patient's **Height** in feet and inches.
- 36. Enter the patient's Weight in pounds and ounces.
- 37. 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. *Required
- 38. 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.
- 39. 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. *Required

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ICD-CM Type Re 40 CD-CM Type Re 41 CD-CM Type Re 41 CD-C	CD Code (Decimal equired)	Diagnosis Description	(4	* Date Of Onset
* Please summarize to characters accepted) 43	treatment/procedures	/surgeries/clinical findings/history relevant	to the requested service	e(s) include dates if applicable. (255
* If it is known that the	e patient has ever rec	eived the requested or similar service(s),	please explain include	dates. (255 characters accepted)
* Please summarize t	the therapeutic goal to	o be met with the requested service(s). (2	55 characters accepted)	

- 40. Use the ICD-CM Type drop-down to select the ICD code type.
- 41. 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.

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

- 42. Enter the **Date of Onset** (mmddyyyy) for the diagnosis entered in the ICD Code field. *Required
- 43. 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. *Required
- 44. 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. *Required
- 45. 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. *Required

Please list alternatives tried or consider this patient	red and the reason why they are not feasible	e for
Service Code (HCPCS Code)	Describe Alternative Tried/Considered (30 characters accepted)	
Reason	48	
Reason		
Reason		
Reason Please explain why the least costly me	thod of treatment is not being used. (255 cha	aracters accepted)
(49)		< >

- 46. 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.
- 47. 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.
- 48. Use the **Reason** drop-down 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.
- 49. Enter a brief explanation in the Please explain why the least costly method of treatment is not being used field.

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Prescribing Physician Inf	ormation
* Physician Prescription (255	characters accepted)
50	
* Physician's License #	* Physician's Name
* Physician's Phone	* Prescription Date
Attachment A Service	
55 Co	ntinue 66 Another Service, Same Category

- 50. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 51. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 52. Enter the prescribing **Physician's Name**. *Required
- 53. Enter the Physician's Phone number. *Required
- 54. Enter the Prescription Date (mmddyyyy). *Required
- 55. Click **Continue** to return to the TAR Service Menu. See the eTAR Basics User Guide for information on submitting the TAR.

Or

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

Note: TAR web pages do not have numbered fields.

Select Service Category

ע 🗌	Find Service Cate	gory(s)		
eTAR Medical Tute Please Select a Service Category When finished with all services, click Submit TAR				TAR Medical Tutorials
DME Services	LTC Services	Inpatient Services	Outpatient Services	Other Services
Apnea Monitor Beds Hearing Aid Incontinence Supplies IV Equipment Medical Supplies Mobility Orthotics/ Prosthetics Ox/Respiratory Pumps (non-IV) Other	 ICF-DD NFA/NFB Non- Electronic MDS Short Stay Subacute 	 Hospital Days Hyperbaric Oxygen Radiology Surgical/Other Procedures Transplant Procedure- Kidney Transplant Procedure-Other 	 Allergy Cochlear Implants CPSP Dialysis FPACT HopTel Hyperbaric Oxygen Radiology Office Visits - Restricted Office Visits - Restricted Provider Plasma Pheresi Portable X-ray Psychiatry Surgical/Other Procedures TeleMed Transplant 	 AAC ADHC Detox EPSDT Nutritional Home Health Hospice Non-Pharmacy Issued Drug Respiratory Therapy Speech/ Occupational /Physical Therapy Vision - Contact Lens / Evaluatio Vision - Low Vision - Other Eye Appliances

There are three ways to add a service to the TAR:

- 57. If you know the code, enter the code in the search field and select **Find Service Category(s)**. This is the preferred method.
- 58. If you don't know the code, but you know the service category, select the appropriate Service Category hyperlink.
- 59. If you don't know the code or the service category, select the **Service Code Search** hyperlink to initiate the search. See the eTAR User Guide: Basics for additional information on code search.

Contact Lens

Vision Service	
	eTAR Medical Tutorials
Please Enter Contact Lens Infor	nation
Attachment A Attachment G Cont	inue
Service Information	
* Service Code (HCPCS Code)	* Modifiers
Service Description (40 characters accepted)	
(3)	
* Total Units 4 5 mmddyyyy	* Thru Date 6 mmddyyyy
* POS	Rendering Provider #

- 1. Enter the **Service Code** being requested if blank. If the service code is unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**. If unknown, click the Modifiers link to access Code Search. *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. *Required
- 5. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range if dates during which service will be provided.*Required
- Enter the Thru Date (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range if dates during which service will be provided.*Required
- 7. Use the **POS** drop-down list to select the location where the service is being rendered. *Required

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

- 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 to select an override code for unlisted items or prices.
- 10.1Enter 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 to select the ICD code type. *Required
- 13. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *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.

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Patient assessment information for this Service (Attachment A)	
Please list current functional limitation /physical condition codes	
Please list previous functional limitation /physical condition codes	
Please list current medical status codes relevant to requested service(s)	
ICD-CM ICD Code (Decimal	
Type Required) Diagnosis Description	Date Of Onset
	(21)

- 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.
- 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.
- 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.
- 19. Use the ICD-CM Type drop-down 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 hyperlink to access 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/histo service(s) include dates if applicable. (255 characters accepted)	ry relevant to the requested
	~
	×
If it is known that the patient has ever received the requested or similar include dates. (255 characters accented)	service(s), please explain
23	~
23	< >
Please summarize the therapeutic goal to be met with the requested ser accepted)	vice(s). (255 characters
Please summarize the therapeutic goal to be met with the requested ser accepted)	vice(s). (255 characters

- 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.

Describe Alternative 26 accepted)	e Tried/Considered (30 characters
27 Reason	
Reason	~
ase explain why the least costly method of treatment is	not being used. (255 characters accepted)

- 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 hyperlink to access 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 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 Informa Physician Prescription (255 chara	ation octers accepted)	
29 Physician's License # 30 Physician's Phone 32 () -	Physician's Name	~

- 29. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 30. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 31. Enter the prescribing Physician's Name. *Required
- 32. Enter the **Physician's Phone** number. *Required
- 33. Enter the **Prescription Date** (mmddyyyy). *Required

Attachment A Servi	Continue	
Vision Attachment Fo	orm (Attachment G)	
Date of Comprehensive	Eye	
Exam 34 mmddyyyy	Date of Prior Eye Exam	 * First Time Wearer 36 No O Yes
* Replacement?	Replacement Reason	
No O Yes	38	~
		*
		*

- 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. *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. *Required
- 38. If the circular Replacement radio button was selected as "Yes," use the **Replacement Reason** drop-down 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		
Distance	(39)	
Near	40	
Refraction Results		
* Sphere	(41) Diopters	Diopters
* Cylinder	(42) Diopters	Diopters
*Axis	43 Degrees	Degrees
* Add Power	44 Diopters	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. *Required
- 42. Enter the right and left eye **Cylinder** power (astigmatism) of the spectacle prescription. *Required
- 43. Enter the right and left eye **Axis** (direction of the cylinder power) of the spectacle prescription. *Required
- 44. Enter the right and left eye **Add Power** (magnification power added to sphere power for near vision). *Required

Best Corrected Visual Acuity		
* Distance	45	
Near	46	
* Keratometry		
* Grade of Mire Distortion	48	*
* Manufacturer	49	
* Model	50	
* Wear	51 💿 Extended 🔘 Daily	💿 Extended 🔘 Daily
* Wearing Schedule	52	¥

- 45. Enter the right and left eye **Distance** visual acuity measured with spectacles (measurement of ability to distinguish fine detail). *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. *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. *Required
- 49. Enter the name of the Manufacturer of the requested eye appliance. *Required
- 50. Enter the **Model** number or name of the requested eye appliance in the right and left eye. *Required
- 51. Click the circular **Wear** radio button to indicate if the patient will wear daily or extended contact lenses. *Required
- 52. Use the **Wearing Schedule** drop-down lists to select the wearing schedule of the right and left contact lens. *Required

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Contact Lens		
* Base Curve	53	
* Diameter	54 mm	mm
* Power	55 Diopters	Diopters
* Visual Acuity thru Eye Appliances	56	
Attachment A Attachment G Services	57 Continue 58 Anot	her Service, Same Category

- 53. Enter the right and left eye **Base Curve** of the posterior surface in the area corresponding to the optic zone. *Required
- 54. Enter the right and left eye **Diameter** for the contact lens in millimeters. *Required
- 55. Enter the right and left eye Power of the contact lens. *Required
- 56. Enter the right and left eye near Visual Acuity thru Eye Appliances. *Required
- 57 Click **Continue** to return to the TAR Service Menu. See the eTAR User Guide: Basics for information on submitting the TAR.

Or

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

C Vision Care Services Page updated: September 2020

Low Vision Aids

Vision Service	
	eTAR Medical Tutorials
Please Enter Low Vision Aids Informatio	n
Attachment A Attachment G Continue	
Service Information	
* Service Code (HCPCS Code) * Modifiers	;
Service Description (40 characters accepted)	
3	
* Total Units * From Date	* Thru Date
4 5mmddyyyy	6 mmddyyyy
* POS	Rendering Provider #

- Enter the Service Code being requested if blank. If the service code is unknown, click the Service Code hyperlink to access Code Search. See the eTAR Basics User Guide for more information on Code Search. *Required
- 2. Enter up to four **Modifiers**. If unknown, click the Modifiers hyperlink to access Code Search. *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. *Required
- 5. Enter the **From Date** (mmddyyyy) for the requested start of service date. This field is required if the request is retroactive. If request is planned, enter range if dates during which service will be provided. *Required
- 6. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. This field is required if the request is retroactive. If request is planned, enter range if dates during which service will be provided. *Required
- 7. Use the **POS** drop-down list to select the location where the service is being rendered. *Required

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* POS	Rendering Provider #
Pricing Override Request	Price MSRP 10 11
* ICD Code (Decimal * ICD-CM Type 12 13 13 13 13 13 13 13 13 13 13	Date of Onset
Enter Miscellaneous TAR Information (500 characters accepted)	Land 1
	<u>^</u>
	-

- 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 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 to select the ICD code type. *Required
- 13. Enter the ICD Code indicating the primary diagnosis relative to the requested service, including the decimal point. If unknown, click the ICD Code hyperlink to access Code Search. *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.

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Patient assessment information for this Service (Attachment A)	
Please list current functional limitation /physical condition codes	
Please list previous functional limitation /physical condition codes	
Please list current medical status codes relevant to requested service(s)	
ICD-CM ICD Code (Decimal	
Type Required) Diagnosis Description	Date Of Onset
(19) 20	-(21)

- 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.
- 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.
- 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.
- 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 hyperlink to access Code Search. *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)	
	< >
If it is known thatthe 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 consider patient	red and the reason why they are not feasible for this	
Service Code	Describe Alternative Tried/Considered (30 characters accepted)	
Reason	27	
Reason		
Please explain why the least costly method of treatment is not being used. (255 characters accepted)		

- 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 hyperlink to access 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)	
Physician's License #	Physician's Name	~ ~
30	31	
Physician's Phone	Prescription Date	

- 29. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 30. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 31 Enter the prescribing Physician's Name. *Required
- 32. Enter the Physician's Phone number. *Required
- 33. Enter the Prescription Date (mmddyyyy). *Required

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Attachment A Servi	ce Continue	
Vision Attachment F	orm (Attachment G)	
Date of Comprehensive		
Eye Exam	Date of Prior Eye Exam	Professional Time Spent
34 mmddyyyy	35 mmddyyyy	36 Hr Min
* Replacement?	Replacement Reason	
	38	
V NO V Yes		
		~
		*
	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** fitting, training and counseling the patient on the use of the low vision aids in hours and minutes.

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

Professional Time Spent			
3	Hr	4	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. *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	
Distance	39	
Near	40	
Refraction Results		
* Sphere	(41) Diopters	Diopters
* Cylinder	42 Diopters	Diopters
* Axis	(43) Degrees	Degrees
* Add Power	(44) Diopters	Diopters
Best Corrected Visi	ual Acuity	
* Distance	(45)	
Near	46	

- 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. *Required
- 42. Enter the right and left eye **Cylinder** power (astigmatism) of the spectacle prescription. *Required
- 43. Enter the right and left eye **Axis** (direction of the cylinder power) of the spectacle prescription. *Required
- 44. Enter the right and left eye **Add Power** (magnification power added to sphere power for near vision). *Required
- 45. Enter the right and left eye **Distance** visual acuity measured with spectacles (measurement of ability to distinguish fine detail). *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			Degrees	*
V	Isual Field Constriction		begrees		Degrees	
A	Visual Acuity thru Eye Appliances	(49)				
*	Sensitivity To Glare					
50	~					
*	Manufacturer	* Model	_	* Model Descript	ion	
51		52	5	3)		
*	Purpose of Low Vision	Aid				
						< >

- 47. Use the **Type of Visual Field Defects** drop-down to select the type of visual field defect in the right and left eye. *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. *Required
- 50. Use the **Sensitivity to Glare** drop-down to select the degree of annoyance, discomfort or loss in visual performance caused by light. *Required
- 51. Enter the name of the Manufacturer of the requested eye appliance. *Required
- 52. Enter the Model number or name of the requested eye appliance. *Required
- 53. Enter the **Model Description** of the low vision aid. (Example: 2.8X monocular telescope). *Required

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* Type of Visual Field Defects		~		~	
Visual Field Constriction		Degrees		Degrees	
* Visual Acuity thru Eye Appliances]	
* Sensitivity To Glare					
	* Madel				
- manufacturer	- Model		- Model Descript	ion	
* Purpose of Low Vision Aid					
					< >
Attachment A Attachment	G Services	Another Ser	vice, Same Ca	tegory	Ъ
				- 37	

- 54. Enter the **Purpose of Low Vision Aid.** *Required
- 55. Click **Continue** to return to the TAR Service Menu. See the eTAR User Guide: Basics for information on submitting the TAR.

Or

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

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Other Eye Appliances

Vision Service	
	eTAR Medical Tutorials
Please Enter Other Eye Appliances Info	mation
Attachment A Attachment G Continue	
Service Information	
* Service Code (HCPCS Code) * Mod	ifiers
Service Description (40 characters accepted)	
* Total Units 4 * From Date 5 mmddyyyy	* Thru Date 6 mmddyyyy
* POS	Rendering Provider #

- 1. Enter the **Service Code** being requested if blank. If the service code is unknown, click the Service Code hyperlink to access Code Search. See the eTAR User Guide: Basics or more information on Code Search. *Required
- 2. Enter up to four **Modifiers**. If unknown, click the Modifiers hyperlink to access Code Search. *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. *Required
- 5. Enter the **From Date** (mmddyyyy) for the requested start of service date. If request is planned, enter range if dates during which service will be provided.*Required
- 6. Enter the **Thru Date** (mmddyyyy) for the requested end of the service date. If request is planned, enter range if dates during which service will be provided.*Required
- 7. Use the **POS** drop-down list to select the location where the service is being rendered. *Required

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* POS		Rendering Pro	ovider #
Pricing Override Request	v	Price 10	MSRP 11
* ICD-CM Type 12 13 13 13 13 13 13 13 13 13 13	Diagnosis Description		Date of Onset
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 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 to select the ICD code type. *Required
- 13. Enter the **ICD Code**, including the decimal point, indicating the primary diagnosis relative to the requested service. If unknown, click the ICD Code hyperlink to access Code Search. *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.

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Patient assessment information for this Service (Attachment A)	
Please list current functional limitation /physical condition codes	
Please list previous functional limitation /physical condition codes	
(17)	
Please list current medical status codes relevant to requested service(s)	
ICD-CM ICD Code (Decimal Type Required) Diagnosis Description	Date Of Onset
(19) (20)	21
v	

- 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.
- 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.
- 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.
- 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.

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/histo service(s) include dates if applicable. (255 characters accepted)	ory relevant to the requested
<u>n</u>	~
	~
If it is known that the patient has ever received the requested or similar include dates. (255 characters accepted)	service(s), please explain
23)	^
	~
Please summarize the therapeutic goal to be met with the requested ser accepted)	vice(s). (255 characters
24	~
	1

- 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 consider	red and the reason why they are not feasible for this patient
Service Code	Describe Alternative Tried/Considered (30 characters accepted)
(25)	26
Reason	<i>u v</i>
Reason	~
Please explain why the least costly me	thod 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.
- 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 acc	cepted)	
	-	< >
Physician's License #	Physician's Name	
Physician's Phone	Prescription Date	

- 29. Enter the **Physician Prescription** instructions in the exact words as written on the prescription. *Required
- 30. Enter the National Provider Identifier (NPI) in the Physician's License # field. *Required
- 31. Enter the prescribing Physician's Name. *Required
- 32. Enter the **Physician's Phone** number. *Required
- 33. Enter the **Prescription Date** (mmddyyyy). *Required

Attachment A	Service Continue			
Vision Attachme	ent Form (Attachment G)			
* Date of Compreh Eve Exam 34 mmddyyyy	ensive			
* Replacement? 35 No 🔿 Yes	Replacement 36	Reason	*	
	Right Eye (OD)		Left Eye (OS)	
Uncorrected Vis	ual Acuity	-		-
Distance	37			
Near	38			
Refraction Resul	Its			
* Sphere	39	Diopters		Diopters
* Cylinder	40	Diopters		Diopters

- 34. Enter the Date of the Comprehensive Eye Exam (mmddyyyy). *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. *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.
C Vision Care Services

	Right Eye (OD)	Left Eye (OS)
Uncorrected Visual Acuity	37	
Distance	, , , , , , , , , , , , , , , , , , ,	
Near	38	
Refraction Results	(39)	
* Sphere	Diopters	Diopters
* Cylinder	40 Diopters	Diopters
* Axis	Degrees	Degrees
* Add Power	Diopters	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. *Required
- 40. Enter the right and left eye **Cylinder** power (astigmatism) of the spectacle prescription. *Required.
- 41. Enter the right and left eye **Axis** (direction of the cylinder power) of the spectacle prescription. *Required
- 42. Enter the right and left eye **Add Power** (magnification power added to sphere power for near vision). *Required

C Vision Care Services

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Best Corrected Visual Acuity		
* Distance	43	
Near	44	
	(AF)	
Keratometry	43	
Grade of Mire Distortion	46	~
Type of Visual Field Defects	47	×
Visual Field Constriction	48 Degrees	Degrees
* Visual Acuity thru Eye Appliances	49	
Sensitivity To Glare		
50 💌		
Attachment A Attachment G Services		
	51 Continue 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). *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 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. *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 the eTAR User Guide: Basics for information on submitting the TAR.

Or

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

Note: TAR web pages do not have numbered fields

Appendix A: eTAR Glossary

Medical Status Codes and Descriptions

Medical Status Codes	Description
001	Symptom control: Asymptomatic, no treatment needed at this time
002	Symptom control: well controlled with current therapy
003	Symptom control: Difficult, affects ADLs; patient needs ongoing monitoring
004	Symptom control: Poor, patient needs frequent adjustment
005	Symptom control: Poor, history of hospitalizations
011	IV: hydration only
012	IV: chemotherapy
013	IV: blood/blood products
014	IV medication: continuous with/without pump
015	IV medication: intermittent with/without pump
016	IV medication: bolus
017	Parenteral nutrition (TPN or lipids): central
018	Parenteral nutrition (TPN or lipids): peripheral
019	Enteral nutrition (ng, g-tube, jejunostomy, other artificial entry into alimentary canal)
021	Drainage tube: Chest
022	Drainage tube: Nasogastric
023	Drainage tube: Gastrostomy
024	Drainage tube: Jackson Pratt
025	Drainage tube: Hemovac
026	Drainage tube: Urinary
027	Drainage tube: Intracranial/ intraventricular
031	Prognosis: Little or no recovery is expected and/or further decline is imminent

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Medical Status Codes	Description
032	Prognosis: Partial to full recovery is expected
033	Prognosis: Minimal improvement in functional status is expected, decline is possible
034	Prognosis: Marked improvement in functional status is expected
035	Life expectancy: greater than 6 months
036	Life expectancy: 6 months or fewer
041	Pain Description: Aching
042	Pain Description: Throbbing
043	Pain Description: Constant
044	Pain Description: Intermittent
045	Pain Description: Sharp
046	Pain Description: Dull
047	Pain Description: Widespread
048	Pain Description: Localized
049	Pain Description: Intractable
061	Pain Location: Abdominal
062	Pain Location: Chest
063	Pain Location: Back
064	Pain Location: Head
065	Pain Location: Face
066	Pain Location: Ear
067	Pain Location: Eye
068	Pain Location: Mouth
069	Pain Location: Throat
070	Pain Location: Neck
071	Pain Location: Foot

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Medical Status Codes	Description
072	Pain Location: Leg
073	Pain Location: Hand
074	Pain Location: Arm
075	Pain Location: Pelvis
076	Pain Location: Hip
077	Pain Location: Buttocks
078	Pain Location: Perineal/Genital Area
079	Pain Location: Joints (generalized)
081	Pain Frequency: Less often than daily
082	Pain Frequency: Daily, but not constantly
083	Pain Frequency: Constantly
091	Pain Management: No current pain management
092	Pain management: Non-medication methods
093	Pain management: Oral analgesics
094	Pain management: Topical analgesics
095	Pain management: IM analgesics
096	Pain management: IV analgesics
097	Pain Management: Pump analgesia (chronic)
099	Pain management: Combination (oral/topical/IM/IV)
101	Lesion: Head/torso, front
102	Lesion: Head/torso, back
103	Lesion: LUE
104	Lesion: RUE
105	Lesion: LLE
106	Lesion: RLE
111	Open wound(s), head/torso, front

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Medical Status Codes	Description
112	Open wound(s), head/torso, front: not healing
113	Open wound(s), head/torso, back
114	Open wound(s), head/torso, back: not healing
115	Open wound(s), LUE
116	Open wound(s), LUE: not healing
117	Open wound(s), RUE
118	Open wound(s), RUE: not healing
119	Open wound(s), LLE
120	Open wound(s), LLE, not healing
121	Open wound(s), RLE
122	Open wound(s), RLE: not healing
131	Surgical wound(s), head/torso, front
132	Surgical wound(s), head/torso, front: not healing
133	Surgical wound(s), head/torso, back
134	Surgical wound(s), head/torso, back: not healing
135	Surgical wound(s), LUE
136	Surgical wound(s), LUE: not healing
137	Surgical wound(s), RUE
138	Surgical wound(s), RUE: not healing
139	Surgical wound(s), LLE
140	Surgical wound(s), LLE, not healing
141	Surgical wound(s), RLE
142	Surgical wound(s), RLE: not healing
151	Pressure ulcer(s), head/torso, front: worst ulcer = Stage I
152	Pressure ulcer(s), head/torso, front: worst ulcer = Stage II
153	Pressure ulcer(s), head/torso, front: worst ulcer = Stage III

A	eTAR User	Guide: Med	cal Services	, Allied Health,	& Vision	Care Services
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Medical Status Codes	Description
154	Pressure ulcer(s), head/torso, front: worst ulcer = Stage IV
155	Pressure ulcer(s), head/torso, back: worst ulcer = Stage I
156	Pressure ulcer(s), head/torso, back: worst ulcer = Stage II
157	Pressure ulcer(s), head/torso, back: worst ulcer = Stage III
158	Pressure ulcer(s), head/torso, back: worst ulcer = Stage IV
159	Pressure ulcer(s), LUE: worst ulcer = Stage I
160	Pressure ulcer(s), LUE: worst ulcer = Stage II
161	Pressure ulcer(s), LUE: worst ulcer = Stage III
162	Pressure ulcer(s), LUE: worst ulcer = Stage IV
163	Pressure ulcer(s), RUE: worst ulcer = Stage I
164	Pressure ulcer(s), RUE: worst ulcer = Stage II
165	Pressure ulcer(s), RUE: worst ulcer = Stage III
166	Pressure ulcer(s), RUE: worst ulcer = Stage IV
167	Pressure ulcer(s), LLE: worst ulcer = Stage I
168	Pressure ulcer(s), LLE: worst ulcer = Stage II
169	Pressure ulcer(s), LLE: worst ulcer = Stage III
170	Pressure ulcer(s), LLE: worst ulcer = Stage IV
171	Pressure ulcer(s), RLE: worst ulcer = Stage I
172	Pressure ulcer(s), RLE: worst ulcer = Stage II
173	Pressure ulcer(s), RLE: worst ulcer = Stage III
174	Pressure ulcer(s), RLE: worst ulcer = Stage
181	Stasis ulcer(s), head/torso, front
182	Stasis ulcer(s), head/torso, front: not healing
183	Stasis ulcer(s), head/torso, back
184	Stasis ulcer(s), head/torso, back: not healing
185	Stasis ulcer(s), LUE

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Medical Status Codes	Description
186	Stasis ulcer(s), LUE: not healing
187	Stasis ulcer(s), RUE
188	Stasis ulcer(s), RUE: not healing
189	Stasis ulcer(s), LLE
190	Stasis ulcer(s), LLE: not healing
191	Stasis ulcer(s), RLE
192	Stasis ulcer(s), RLE: not healing
301	Breathing sounds: Clear
302	Breathing sounds: Decreased
303	Breathing sounds: Increased
304	Breathing sounds: Dullness
305	Breathing sounds: Rales
306	Breathing sounds: Rhonchi
307	Breathing sounds: Wheezing, expiratory
308	Breathing sounds: Wheezing, inspiratory
311	Dyspneic or noticeably SOB: walking less than 20 feet
312	Dyspneic or noticeably SOB: moderate exertion (while dressing, toileting, walking < 20 feet)
313	Dyspneic or noticeably SOB: minimal exertion (while eating, talking, or performing other ADLs)
314	Dyspneic or noticeably SOB: at rest
315	Dyspneic or noticeably SOB: Orthopneic
321	Chest pain: with radiation to RUE/LUE
322	Chest pain: progressive
323	Chest pain: on exertion
324	Chest pain: at rest
330	Residential respiratory treatments: oxygen: intermittent

А	eTAR User	Guide: Me	dical Services	, Allied Health,	& Vision	Care Services
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Appendix A: eTAR	Glossary	(continued)
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Medical Status Codes	Description
331	Residential respiratory treatments: oxygen: continuous
332	Residential respiratory treatments: oxygen: at night
333	Residential respiratory treatments: ventilator: continuously
334	Residential respiratory treatments: ventilator: intermittent
335	Residential respiratory treatments: ventilator: at night
336	Residential respiratory treatments: percussion & drainage: intermittent
337	Residential respiratory treatments: percussion & drainage: infrequently
338	Residential respiratory treatments: suctioning: oral
339	Residential respiratory treatments: suctioning: nasopharyngeal
340	Residential respiratory treatments: suctioning: tracheostomy
341	Residential respiratory treatments: nebulizer with medication
342	Residential respiratory treatments: metered dose inhalers
343	Residential respiratory treatments: oximeter
344	Residential respiratory treatments: CPAP
345	Residential respiratory treatments: Bi-PAP
346	Residential respiratory treatments: air mist
347	Residential respiratory treatments: IPPB
348	Residential respiratory treatments: apnea/cardiac monitor
351	Cardiac: palpitation: regular
352	Cardiac: palpitation: irregular
353	Cardiac: palpitation: paroxysmal
354	Cardiac: arrhythmia
355	Cardiac: tachycardia
356	Cardiac: bradycardia
357	Cardiac: pacemaker
361	Bowel: incontinence: occasional

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Description	
Bowel: incontinence: frequent	
Bowel: incontinence: total	
Bowel: Patient has ostomy for bowel elimination	
Bowel: Blood in stool (melena)	
Bowel: Constipation	
Bowel: Diarrhea	
Urinary: incontinence: occasional	
Urinary: incontinence: frequent	
Urinary: incontinence: total	
Urinary: Intermittent catheterization	
Urinary: Foley catheter (indwelling)	
Urinary: Condom catheter	
Urinary: Urostomy	
Urinary: Urinary conduit	
Urinary: Indwelling/suprapubic catheter	
Urinary: stents	
Urinary: Urinary tract infection	
Urinary: Blood in urine (hematura)	
Allergy: None known	
Allergy: tetracycline	
Allergy: sulphonamides	
Allergy: other antibiotics	
Allergy: anticholinergic	
Allergy: anti-epileptics	
Allergy: animal serum	
Allergy: pollen	

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Medical Status Codes	Description
400	Allergy: Latex
401	Allergy: analgesics
402	Allergy: anti-rheumatics
411	Risk factor: Smoking
412	Risk factor: Obesity
413	Risk factor: Eating disorder
414	Risk factor: Alcohol dependency
415	Risk factor: Drug dependency
416	Risk factor: SIDS sibling
417	Risk factor: Strong family history of high risk factors
421	General patient condition: Pregnancy
422	General patient condition: Implanted medical device (non-pacemaker)
423	General patient condition: Coughing
424	General patient condition: Blood in sputum (hemoptysis)
425	General patient condition: Nausea and vomiting
426	General patient condition: Vomit with blood (hematemisis)
427	General patient condition: Sleep Apnea
428	General patient condition: Syncope
429	General patient condition: Dizziness/lightheadedness
430	General patient condition: Fever (febrile)
431	General patient condition: Jaundiced
432	General patient condition: Cyanosis
433	General patient condition: Seizures
434	General patient condition: Tremors
435	General patient condition: Edema: generalized
436	General patient condition: Edema: peripheral

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Description
General patient condition: Tinnitus
General patient condition: Herniated disk
General patient condition: Clubbing
Patient behavior: Sleep disturbances
Patient behavior: Recent change in appetite
Patient behavior: Disruptive, infantile or socially inappropriate behavior: nonverbal
Patient behavior: Disruptive, infantile or socially inappropriate behavior: verbal
Patient behavior: Physical aggression towards self
Patient behavior: physical aggression towards others
Patient behavior: Suicide attempt
Patient behavior: Flat affect
Patient behavior: Mood changes
Patient behavior: Tearful
Patient behavior: Delusional
Patient behavior: Hallucinations
Patient behavior: Paranoid
Patient behavior: Anxiety
Patient behavior: Fearful
Patient behavior: Wandering episodes

Appendix B: eTAR Glossary

Functional Limitation Codes and Descriptions

Function Limitation Codes	Description
501	Ambulation: Independent: steady gait
502	Ambulation: Independent: unsteady gait
503	Ambulation: Independent: history of falls
504	Ambulation: Independent: limited distance (less than 20 feet)
505	Ambulation: Requires use of device to walk alone
506	Ambulation: assistance: cane
507	Ambulation: assistance: crutches
508	Ambulation: assistance: braces
509	Ambulation: assistance: prosthesis
510	Ambulation: assistance: walker
511	Ambulation: assistance: human help needed for steps or uneven surface
512	Ambulation: assistance: human help needed to walk at all times
513	Ambulation: assistance: human help needed to stand
514	Ambulation: wheelchair-bound: independent
515	Ambulation: wheelchair-bound: unable to wheel self
516	Ambulation: bed-bound: positions self
517	Ambulation: bed-bound: requires assistance to position
518	Ambulation: bed-bound: requires mechanical assistance to leave bed
531	Physical limitation: quadriplegia
532	Physical limitation: paraplegia
533	Physical limitation: left hemiplegia
534	Physical limitation: right hemiplegia
535	Physical limitation: bilateral amputee: lower extremities
536	Physical limitation: bilateral amputee: upper extremities
537	Physical limitation: amputee: LLE

Function Limitation Codes	Description
538	Physical limitation: amputee: RLE
539	Physical limitation: amputee: LUE
540	Physical limitation: amputee: RUE
541	Physical limitation: contracture(s): LLE
542	Physical limitation: contracture(s): RLE
543	Physical limitation: contracture(s): LUE
544	Physical limitation: contracture(s): RUE
545	Physical limitation: generalized weakness
546	Physical limitation: weakness: right side
547	Physical limitation: weakness: left side
548	Physical limitation: weakness: bilateral lower extremities
549	Physical limitation: weakness: bilateral upper extremities
550	Physical limitation: limited ROM: head/neck
551	Physical limitation: limited ROM: trunk
552	Physical limitation: limited ROM: LLE
553	Physical limitation: limited ROM: RLE
554	Physical limitation: limited ROM: LUE
555	Physical limitation: limited ROM: RUE
561	Vision: sees clearly using eyeglasses
562	Vision: sees clearly using contact lenses
563	Vision: minimally impaired: sees objects clearly, cannot read print
564	Vision: partially impaired: sees shapes, objects
565	Vision: severely impaired: sees light/dark, some shapes
566	Vision: blind: one eye
567	Vision: blind: both eyes

Function Limitation Codes	Description
571	Hearing/comprehension: no deficits, naturally or with a hearing aid
572	Hearing/comprehension: moderate deficits: one-step instruction and brief conversation
573	Hearing/comprehension: severe deficits: simple greetings and short comments
574	Hearing/comprehension: severe deficits: unable to hear and understand consistently
575	Hearing/comprehension: deaf
576	Hearing/comprehension: cochlear implant
581	Communication: nonverbal
582	Communication: device: board
583	Communication: device: writing
584	Communication: device: instrument/mechanical/computer
585	Communication: American Sign Language
586	Communication: speech: slurred
587	Communication: speech: stutters
588	Communication: speech: aphasia: sensory
589	Communication: speech: aphasia motor
590	Communication: speech: minimal difficulty expressing ideas and needs
591	Communication: speech: moderate difficulty expressing simple ideas or needs
592	Communication: speech: severe difficulty expressing basic ideas or needs
593	Communication: speech: interpreter required
594	Communication: unable to express basic needs but is not comatose or unresponsive
595	Communication: patient is non-responsive

Function Limitation Codes	Description
601	Cognitive functioning alert
602	Cognitive functioning: oriented
603	Cognitive functioning: impaired decision-making
604	Cognitive functioning: requires prompting under stressful or unfamiliar condition
605	Cognitive functioning: requires assistance and direction in specific situations
606	Cognitive functioning: distractibility: requires low stimulus environment
607	Cognitive functioning: requires considerable assistance in routine situations
608	Cognitive functioning: disorientation, coma, persistent, vegetative state or delirium
609	Confusion: new or complex situations
610	Confusion: upon awakening or at night
611	Confusion: during sundown/twilight
612	Confused: constantly
613	Memory deficit: failure to recognize familiar persons or places
614	Memory deficit: inability to recall events of past 24 hours
615	Memory deficit: to the extent that supervision is required
621	Feeding/Eating: independent
622	Feeding/Eating: requires meal set-up
623	Feeding/Eating: requires intermittent aid or supervision
624	Feeding/Eating: requires total feeding assistance/supervision
625	Feeding/Eating: mechanical soft diet
626	Feeding/Eating: liquid/pureed diet
627	Feeding/Eating: takes in nutrients orally AND receives oral supplements

Function Limitation Codes	Description
628	Feeding/Eating: takes in nutrients orally AND receives enteral supplements
629	Feeding/Eating: total enteral nutrition (ng. g-tube, j-tube, other)
630	Feeding/Eating: unable to take in nutrients orally or by tube feeding
631	Feeding/Eating: dysphagia
641	Feeding/Eating: able to prepare light meals
642	Feeding/Eating: unable to prepare light meals on a regular basis
643	Feeding/Eating: unable to prepare ANY light meals
651	Medication: able to independently administer all medications
652	Medication: oral: needs dose preparation, daily reminders or a drug chart
653	Medication: oral: must be administered by someone else
654	Medication: topical: needs dose preparation, daily reminders or a drug chart
655	Medication: topical: must be administered by someone else
656	Medication: inhalants/mist: needs dose preparation, daily reminders or a drug chart
657	Medication: inhalants/mist: must be administered by someone else
658	Medication: injections: needs dose preparation, daily reminders or a drug chart
659	Medication: injections: must be administered by someone else
660	Medication: patient non-compliant with medication regimen
671	Equipment: patient manages all related tasks
672	Equipment: patient requires assistance with setup
673	Equipment: patient requires assistance to operate
674	Equipment: patient is completely dependent on others
675	Equipment: caregiver manages all related tasks

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Function Limitation Codes	Description
676	Equipment: caregiver requires assistance with setup
677	Equipment: caregiver requires assistance to operate
678	Equipment: caregiver is completely dependent on others
691	Barriers: stairs: used to access toileting, sleeping and/or eating areas
692	Barriers: stairs: used optionally (e.g., to access laundry facilities)
693	Barriers: stairs: leading from inside to outside
694	Barriers: doorways: narrow or obstructed
695	Barriers: hallways: narrow or obstructed
696	Barriers: living environment: small or cluttered
701	Transportation: able to independently drive a regular or adapted car
702	Transportation: uses a regular or handicap accessible public bus
703	Transportation: able to ride in car driven by another person
704	Transportation: able to use a bus or handicap van with assistance
705	Transportation: unable to rise in a car, taxi, bus or van
801	Socioeconomic: lacks electricity
802	Socioeconomic: lacks running water
803	Socioeconomic: lacks telephone
804	Socioeconomic: lacks heat
805	Socioeconomic: lacks refrigeration/appliances
806	Socioeconomic: lacks food
807	Socioeconomic: homeless

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