PARTNERSHIP HEALTHPLAN OF CALIFORNIA
360 Campus Lane, Suite 100
Fairfield, CA 94534
(707) 863-4133 or (800) 863-4144
(707) 863-4118 FAX

TREATMENT AUTHORIZATION REQUEST (TAR) EXTENSION FORM

Healthy kids Health Plan

ADMIT NUMBER (ORIGINAL AUTHORIZATION NUMBER)
ADMIT DATE MM DD YY
AUTH EXP. MM DD YY
EMER ADMIT
VERBAL CONTROL

PATIENT ID NO.
SEX
DATE OF BIRTH MM DD YY
AGE

PROVIDER NUMBER*
*If you do NOT have a PHC HK Provider Number, please contact the Provider Relations Department at 707-863-4100.
PROVIDER PHONE NO. ( )

PATIENT NAME
OTHER COV

PROVIDER NAME

NUMBER OF DAYS REQUESTED
TYPE OF DAYS
RETRO ACTIVE MM DD YY

ADMITTING ICD9-CM

PROVIDER STREET / MAILING ADDRESS

ADMITTING DIAGNOSIS DESCRIPTION

PROVIDER CITY, STATE AND ZIP CODE

FOR PHYSICIAN - PLEASE PROVIDE SUFFICIENT ESSENTIAL DETAIL TO PERMIT A RESONABLE EVALUATION OF THE LENGTH AND LEVEL OF CARE REQUESTED.

CURRENT DIAGNOSIS
CURRENT ICD9-CM CODE

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS.

DESCRIBE CURRENT CONDITION REQUIRING EXTENSION, INCLUDE PERTINENT LAB AND X-RAY REPORTS WITH DATES.

LIST THE PROCEDURES THAT WIL REQUIRE AN EXTENSION OF THIS HOSPITAL STAY. INCLUDE DATES WHEN POSSIBLE.

HOSPITAL: TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PROVIDER
/ / DATE

TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN.

SIGNATURE OR RESPONSIBLE PHYSICIAN
X / /

VALIDATING INFORMATION AND EXPLANATION

CHART REVIEWS

REVIEW COMMENTS INDICATOR

FOR PHC USE ONLY

X DENIED
X DEFERRED
X APPROVED AS REQUESTED
X APPROVED AS MODIFIED

FROM M M D D Y Y
M M D D Y Y

DAYS D D
ACUTE
ACUTE ADMIN
SUB ADMIN VENT
SUB ADMIN N-VENT

DAYS OF THE HOSPITALIZATION ARE DENIED (SEE COMMENTS)

DATES OF DAYS DENIED
M M D D
1 2 3 4 5 6

PARTNERSHIP HEALTHPLAN OF CA CONSULTANT
BY
DATE M M D D Y Y

TAR CONTROL NUMBER

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY