



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 FORM (TAR)



(PLEASE TYPE) (FOR PROVIDER USE) (PLEASE TYPE)

REQUEST IS RETROACTIVE? YES NO

PROVIDER PHONE NO. ()

PROVIDER NO.

*If you do NOT have a PHC HK Provider Number, please contact the Provider Relations Department at 707-863-4100.

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS

-
-
-
-
-

PATIENTS AUTHORIZED REPRESENTATIVE (IF ANY)
 ENTER NAME AND ADDRESS:

-
-
-
-

NAME AND ADDRESS OF PATIENT
 PATIENT NAME (LAST, FIRST, M.I.)

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER AREA ()

IDENTIFICATION NO.

SEX AGE DATE OF BIRTH

HOME ACUTE HOSPITAL

FOR PHC USE ONLY

PROVIDER: YOUR REQUEST IS:

APPROVED AS REQUESTED DENIED DEFERRED

APPROVED AS MODIFIED

BY: _____ PHC CONSULTANT'S NAME

DATE REVIEW COMMENT INDICATOR

COMMENTS / EXPLANATION

DIAGNOSIS DESCRIPTION: _____ CURRENT ICD-9CM CODE _____

MEDICAL JUSTIFICATION:

LINE NO.	AUTHORIZED		APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC / UPC OR PROCEDURE CODE	QUANTITY	CHARGES
	YES	NO						
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

SIGNATURE OF PHYSICIAN OR PROVIDER _____ TITLE _____ DATE _____

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

FROM DATE TO DATE

TAR CONTROL NUMBER _____

OFFICE _____ SEQUENCE NUMBER _____ PI _____

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.