



# MEDI-CAL TREATMENT AUTHORIZATION REQUEST FORM (TAR)

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

(PLEASE TYPE)	(FOR PROVIDER USE)	(PLEASE TYPE)																																																																							
<p><b>PLEASE TYPE YOUR NAME AND ADDRESS HERE</b></p> <div style="border: 1px solid black; padding: 5px; min-height: 100px;">           PROVIDER NAME AND ADDRESS            •            •            •            •            •         </div>	<p>REQUEST IS RETROACTIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PROVIDER PHONE NO. ( )</p> <p>FAX # ( )</p> <p>PROVIDER NPI#</p>	<p>PATIENTS AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p>																																																																							
<p>NAME AND ADDRESS OF PATIENT PATIENT NAME (LAST, FIRST, M.I.)</p> <p>STREET ADDRESS</p> <p>CITY, STATE, ZIP CODE</p> <p>PHONE NUMBER AREA ( )</p>		<p><b>FOR PHC USE ONLY</b></p> <p>PROVIDER: YOUR REQUEST IS:</p> <p><input type="checkbox"/> APPROVED AS REQUESTED <input type="checkbox"/> DENIED <input type="checkbox"/> DEFERRED</p> <p><input type="checkbox"/> APPROVED AS MODIFIED</p> <p>BY: _____ PHC CONSULTANT'S NAME</p> <p>DATE: _____ M M D D Y Y</p> <p>REVIEW COMMENT INDICATOR <input type="checkbox"/></p> <p>COMMENTS / EXPLANATION</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>																																																																							
<p>PATIENT IDENTIFICATION NO.</p> <p>SEX <input type="checkbox"/> AGE <input type="checkbox"/> DATE OF BIRTH M M D D Y Y</p> <p><input type="checkbox"/> HOME <input type="checkbox"/> BOARD &amp; CARE</p> <p><input type="checkbox"/> SNF/ICF <input type="checkbox"/> ACUTE HOSPITAL</p>																																																																									
<p>DIAGNOSIS DESCRIPTION: _____</p> <p>MEDICAL JUSTIFICATION: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>		<p>CURRENT ICD-9CM CODE _____</p>																																																																							
<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2">LINE NO.</th> <th colspan="2">AUTHORIZED</th> <th rowspan="2">APPROVED UNITS</th> <th rowspan="2">SPECIFIC SERVICES REQUESTED</th> <th rowspan="2">UNITS OF SERVICE</th> <th rowspan="2">NDC / UPC OR PROCEDURE CODE</th> <th rowspan="2">QUANTITY</th> <th rowspan="2">CHARGES</th> </tr> <tr> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr><td>1</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> <tr><td>2</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> <tr><td>3</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> <tr><td>4</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> <tr><td>5</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> <tr><td>6</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> </tbody> </table>									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"/>				2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>				3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>				4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>				5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>				6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
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<p>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.</p> <p>SIGNATURE OF PHYSICIAN OR PROVIDER _____ TITLE _____ DATE _____</p>						<p>AUTHORIZATION IS VALID FOR SERVICES PROVIDED</p> <p>FROM DATE: _____ TO DATE: _____ M M D D Y Y M M D D Y Y</p> <p>TAR CONTROL NUMBER _____</p> <p>OFFICE _____ SEQUENCE NUMBER _____ PI _____</p>																																																																			

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