



Partnership Advantage

A Partnership HealthPlan of California Medicare Plan

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

360 Campus Lane, Suite 10C

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 NAME AND ADDRESS

MEDICARE PROVIDER NO.

PLEASE TYPE YOUR NAME AND ADDRESS HERE

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 (M M D D Y Y)

HOME ACUTE HOSPITAL

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

FOR PHC USE ONLY

PROVIDER: YOUR REQUEST IS:

APPROVED AS REQUESTED DENIED DEFERRED

APPROVED AS MODIFIED

BY: _____
PHC CONSULTANT'S NAME

DATE (M M D D Y Y) 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"/>			
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"/>			

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 (M M D D Y Y) TO DATE (M M D D M Y Y)

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.