

Treatment Authorization Request (TAR) reference guide for Community Supports (CS) providers. Please use the guide below to submit correct TARs. **Incorrect TARs will be voided.**

Online Services Provider Portal Link: https://provider.partnershiphp.org/UI/Login.aspx

TAR Date Spans:

3 months – Personal Care and Homemaker Services, 2 months – Respite and Housing Deposits Services, 6 months – All other services, 1 day– Sobering Center Services

Housing Transition Navigation: Six months – End date should be six months from the start date.

PHC - eEligibility						
Member Search		of Service will <u>alwa</u> e start date of the T				
1 Dat	te of Service:	7/23/2025			Search Help!	
	irity Number.				· · ·	
	CIN #:				Below is the search Criteria with the search criteria withe search criteria with the search criteria with the search crit	ne Date of Service
	Last Name:				2.CIN (for e.g.: 9999999999)	
	First Name:				3.Last Name AND First Name	
1	Date of Birth:				4.Last Name AND DOB (for e.g. D	OB: 01/01/2015)
		Search Member Clear				
Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	Select

TAR Start & End D	ates	
START DATE:	END DATE: *	TAR TYPE: *
7/23/2025	1/23/2026	Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.
		Community Supports 🗸
SELECT PROVIDER: *		SERVICE PROVIDER DETAILS:
SERVICE PROVIDER ADD	RESS:	PROVIDER FAX# (ON FILE):
PREFERRED RETURN FAX	K#:	PATIENT CURRENT LOCATION: *
		Homeless
IS URGENT:		
No		~





Service Details should be entered and appear exactly as below:

Diagnosis Details & Medical Justification	
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PRIMARY DIAGNOSIS: * (No decimal point needed)	DIAGNOSIS CODE:	DIAGNOSIS DESCRIPTION:
Z5900	Z5900	Homelessness unspecified
SECONDARY DIAGNOSIS: (No decimal point needed)	SECONDARY CODE:	SECONDARY DESCRIPTION:
Search diagnosis based on diagnosis code or its description		

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges		
H0043	SUPPORTED HOUSING, PER DIEM	U6			0	6	0	🖋 Edit	🛍 Delete

A Community Supports (CS) TAR will **always** have a CS Referral Form attached via provider portal: Attachments:

Attachments: 0

Attach supporting documentation here.

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.





Housing Deposits: Two months – End date should be two months from the start date.

Submit the following:

PHC - eEligibility						
Member Search		of Service will <u>alwa</u> e start date of the T				
	ate of Service: aurity Number:	7/23/2025			Search Help!	
•	CIN #:				Below is the search Criteria with 1 1.SSN (for e.g.: 999999999)	- the Date of Service
	First Name:				2.CIN (for e.g.: 9999999999) 3.Last Name AND First Name 4.Last Name AND DOB (for e.g. D	008: 01/01/2015)
	Date of Birth:	Search Member Clear				
Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	Select

START DATE:	END DATE: *	TAR TYPE: *
7/23/2025	9/23/2025	Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.
		Community Supports
SELECT PROVIDER: *		SERVICE PROVIDER DETAILS:
SERVICE PROVIDER ADDRE	ESS:	PROVIDER FAX# (ON FILE):
PREFERRED RETURN FAX#	:	PATIENT CURRENT LOCATION: *
		Homeless





PRIMARY DIAGNOSIS: * (No decimal point needed)			DIAGNOSIS CODE:			DIAGNOSIS DESCRIPTION:			
Z5900		Z5900			Homeles				
SECONDARY D	DIAGNOSIS: (No decimal point needed)		SECOND	ARY CODE:		SECONDARY DESCRIPTION:			
Search diagno	sis based on diagnosis code or its description	n							
ervice De	tails & Additional Notes								
Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges		
Add New Service	OTES: (MAX CHARACTER LIMIT IS 700	U2	;)		0	1	0	₽ Edit	Delet
Add New Service DDITIONAL N andlord Engag	Code DTES: (MAX CHARACTER LIMIT IS 700 gement: 00/00/0000		;)		0	1	0	₽ Edit	Delet
Add New Service DDITIONAL N andlord Engag	Code DTES: (MAX CHARACTER LIMIT IS 700 gement: 00/00/0000		;)		0	1	0	₽ Edit	Deleta
Add New Service DDITIONAL N andlord Engag	Code DTES: (MAX CHARACTER LIMIT IS 700 gement: 00/00/0000		;)		0	1	0		Delet
Add New Service DDITIONAL No andlord Engag Init Inspection	Code DTES: (MAX CHARACTER LIMIT IS 700 gement: 00/00/0000 : 00/00/0000	CHARACTERS				1 Attachments			Deleta
Add New Service DDITIONAL No andlord Engag Init Inspection	Code DTES: (MAX CHARACTER LIMIT IS 700 gement: 00/00/0000 : 00/00/0000 nity Supports (CS) TAR wi	CHARACTERS	have a						Delet
Add New Service DDITIONAL No andlord Engag Init Inspection Commun S Referra	Code DTES: (MAX CHARACTER LIMIT IS 700 gement: 00/00/0000 : 00/00/0000	CHARACTERS	have a			Attachments			Deleta
Add New Service DDITIONAL N andlord Engag Init Inspection Commun S Referra ease ens	Code DTES: (MAX CHARACTER LIMIT IS 700 gement: 00/00/0000 : 00/00/0000 ity Supports (CS) TAR wi al Form attached via provi sure to also provide:	CHARACTERS	have a			Attachments: 0	g documentation	h here.	:nt. Payment is
Andlord Engag Jnit Inspection Commur S Referra lease ens • Lea	Code DTES: (MAX CHARACTER LIMIT IS 700 gement: 00/00/0000 : 00/00/0000 nity Supports (CS) TAR wi al Form attached via provi	CHARACTERS Il always ider porta	have a			Attachments: 0 Attachments: 0 Attach supportin Disclaimer: Author	; g documentation rization does not g eligibility at the tir	n here. guarantee payme me service is reno	:nt. Payment is





Housing Tenancy and Sustaining: Six months – End date should be six months from the start date.

Submit the following:

PHC - eEligibility						•
Member Search		of Service will <u>alwa</u> e start date of the T				
Social Secu	te of Service: urity Number:	7/23/2025			Search Help!	o
•	CIN #: Last Name: First Name:				Below is the search Criteria with 1.SSN (for e.g.: 999999999) 2.CIN (for e.g.: 9999999999) 3.Last Name AND First Name	the Date of Service
	Date of Birth:	Search Member Clear			4.Last Name AND DOB (for e.g.	DOB: 01/01/2015)
Member Identifier/ CIN	Last Name	First Name	Gender Male	Date of Birth	Program Medi-Cal	Actions

START DATE:	END DATE: *	TAR TYPE: *
7/23/2025	1/23/2026	Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.
		Community Supports
SELECT PROVIDER: *		SERVICE PROVIDER DETAILS:
SERVICE PROVIDER ADDR	IESS:	PROVIDER FAX# (ON FILE):
PREFERRED RETURN FAX	#:	PATIENT CURRENT LOCATION: *
		Homeless
IS URGENT:		
No		~





PRIMARY DIAGNOSIS: * (No decimal point needed)	DIAGNOSIS CODE:	DIAGNOSIS DESCRIPTION:
Z59812	Z59812	Housing instability, housed, homelessness in past 12
		months
SECONDARY DIAGNOSIS: (No decimal point needed)	SECONDARY CODE:	SECONDARY DESCRIPTION:
Search diagnosis based on diagnosis code or its description		

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges		
2040	FINANCIAL MGT WAIVER/ SERVICE	U6			0	6	0	🖋 Edit	🛍 Delete
12041	SUPPORT BROKER WAIVER/ 15 MIN	U6			0	6	0	🖋 Edit	🛍 Delete

Add New Service Code

A Community Supports (CS) TAR will **always** have a CS Referral Form attached via provider portal:

Attachments:

Attachments: 0

Attach supporting documentation here.

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.





Personal Care/Homemaker: Three months – End Date should be three months from the start date.

Submit the following:

PHC - eEligibility Member Search		of Service will <u>always</u> start date of the TAR				•
1 Date	of Service:	7/23/2025			Search Help!	
Social Securi	ity Number.					o
2	CIN #:				Below is the search Criteria with	the Date of Service
	Last Name:				1.SSN (for e.g.: 999999999)	
	Last Name.				2.CIN (for e.g.: 9999999999)	
I I I I I I I I I I I I I I I I I I I	First Name:				3.Last Name AND First Name	
Da	ate of Birth:	[4.Last Name AND DOB (for e.g.	DOB: 01/01/2015)
		Search Member Clear				
Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	Select

START DATE:	END DATE: *	TAR TYPE: *
7/23/2025 10/23/2025		Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.
		Community Supports
SELECT PROVIDER: *		SERVICE PROVIDER DETAILS:
SERVICE PROVIDER ADD	RESS:	PROVIDER FAX# (ON FILE):
PREFERRED RETURN FAX	(#:	PATIENT CURRENT LOCATION: *
		Home
IS URGENT:		
No		~





	GNOSIS: * (No decimal p	point needed)		DIAGNOSI	S CODE:	DIAGNOSIS DESCRIPTION:			
Z602		Z602			Problems related to living alone				
SECONDARY	DIAGNOSIS: (No decimal	l point needed))	SECONDA	RY CODE	:	SECONDA	ARY DESCR	RIPTION:
Search diagno	osis based on diagnosis coo	de or its descript	tion						
		_			Units	0			
Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges		

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.





Respite Services: Two months – End date should be two months from the start date.

Submit the following:

PHC - eEligibility						1
Member Search		of Service will <u>always</u> start date of the TAF				
	e of Service:	7/23/2025			Search Help!	
	rity Number: CIN #:				Below is the search Criteria with 1.SSN (for e.g.: 999999999)	o the Date of Service
	Last Name: First Name:				2.CIN (for e.g.: 99999999999) 3.Last Name AND First Name	
D	Date of Birth:				4.Last Name AND DOB (for e.g.	DOB: 01/01/2015)
		Search Member Clear				
Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	Select

START DATE:	END DATE: *	TAR TYPE: *
7/23/2025	9/23/2025	Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.
		Community Supports
SELECT PROVIDER: *		SERVICE PROVIDER DETAILS:
SERVICE PROVIDER ADDI	RESS:	PROVIDER FAX# (ON FILE):
PREFERRED RETURN FAX	<i>"</i> #:	PATIENT CURRENT LOCATION: *
		Home
IS URGENT:		
No		~





RIMARY DIAGNOSIS: * (No decimal point needed)	DIAGNOSIS CODE:	DIAGNOSIS DESCRIPTION:
Z600	Z600	Problems of adjustment to life- cycle transitions
ECONDARY DIAGNOSIS: (No decimal point needed)	SECONDARY CODE:	SECONDARY DESCRIPTION:
Search diagnosis based on diagnosis code or its description		

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges		
S9125	RESPITE CARE, IN THE HOME, P	U6			0	320	0	🖋 Edit	🛍 Delete
	nunity Supports (CS) T erral Form attached via			<mark>e a</mark>		Disclaimer: Autho	S: Ing documentation Inization does not g eligibility at the tin	uarantee payme	

Note: Clicking Submit TAR is equivalent to signature.





Recuperative Care: Six months – End date should be six months from the start date.

Submit the following:

PHC - eEligibility						
Member Search		of Service will <u>alwa</u> e start date of the Tr				
	te of Service:	7/23/2025			Search Help!	
Social Secu	CIN #:				Below is the search Criteria with 1.SSN (for e.g.: 999999999)	o the Date of Service
	Last Name: First Name:				2.CIN (for e.g.: 9999999999) 3.Last Name AND First Name	
	Date of Birth:				4.Last Name AND DOB (for e.g. [00B: 01/01/2015)
		Search Member Clear				
Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	Select

	END DATE: *	TAR TYPE: *
7/23/2025	1/23/2026	Please attach Prescription, MD Order, and Clinical Notes providing medica justification for the requested service.
		Community Supports
ELECT PROVIDER: *		SERVICE PROVIDER DETAILS:
ERVICE PROVIDER ADDRI	ESS:	PROVIDER FAX# (ON FILE):
REFERRED RETURN FAX#	:	PATIENT CURRENT LOCATION: *
		Homeless
S URGENT:		





Diagnosis Details & Medical Justification		
PRIMARY DIAGNOSIS: * (No decimal point needed)	DIAGNOSIS CODE:	DIAGNOSIS DESCRIPTION:
Z5900	Z5900	Homelessness unspecified
SECONDARY DIAGNOSIS: (No decimal point needed)	SECONDARY CODE:	SECONDARY DESCRIPTION:
Search diagnosis based on diagnosis code or its description		

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges		
T2033	RES NOS WAIVER PER DIEM	U6			0	1	0	🖋 Edit	🛍 Delete
Add New Service C	ode								

A Community Supports (CS) TAR will *always* have a CS Referral Form attached via provider portal:

Attachments:

Attachments: 0

Attach supporting documentation here

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.





Short-Term Post-Hospitalization: Six months – End date should be six months from the start date.

Submit the following:

PHC - eEligibility						
Member Search		of Service will <u>alwa</u> e start date of the T.				
•	e of Service:	7/23/2025			Search Help!	
	CIN #:				Below is the search Criteria with 1.SSN (for e.g.: 999999999)	o the Date of Service
	Last Name: First Name:				2.CIN (for e.g.: 99999999999) 3.Last Name AND First Name	
C	Date of Birth:				4.Last Name AND DOB (for e.g. D	00B: 01/01/2015)
		Search Member Clear				
Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	Select

1/23/2026	Please attach Prescription, MD Order, and Clinical Notes providing medica
	Community Supports
	SERVICE PROVIDER DETAILS:
	PROVIDER FAX# (ON FILE):
	PATIENT CURRENT LOCATION: *
	Homeless





PRIMARY DIAG	GNOSIS: * (No decimal point needed)		DIAGNOS	IS CODE:		DIAGNOSIS DESCRIPTION:			
Z5900			Z5900			Homelessness unspecified			
SECONDARY D	ECONDARY DIAGNOSIS: (No decimal point needed)			RY CODE:		SECONDARY DESCRIPTION:			
Search diagnos	sis based on diagnosis code or its description	n							
orvios Dot	tails & Additional Notes								
ervice Dei	tails & Additional Notes								
Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges		
	Service Description SUPPORTED HOUSING, PER MONTH	Modifier 1 U3	Modifier 2	Modifier 3	Units 0	Quantity	Charges 0	🖋 Edit	🛍 Delet
0044	SUPPORTED HOUSING, PER MONTH		Modifier 2	Modifier 3			Ŭ	<i>₿</i> Edit	û Delet
10044	SUPPORTED HOUSING, PER MONTH		Modifier 2	Modifier 3	0		0	₽ Edit	â Delet
10044 Add New Service (SUPPORTED HOUSING, PER MONTH	U3		Modifier 3	0	1	0	<i>₿</i> Edit	Delet
10044 Add New Service (Commur	SUPPORTED HOUSING, PER MONTH	U3	have a	Modifier 3	0	1 Attachments:	0		Delet
	SUPPORTED HOUSING, PER MONTH	U3	have a	Modifier 3	0	1 Attachments: 0	0 : ; documentation zation does not gu	here.	nt. Payment is





Day Habilitation Programs: Six months – End date should be six months from the start date.

Submit the following:

PHC - eEligibility						
Member Search		of Service will <u>always</u> e start date of the TAI				
•	te of Service:	7/23/2025			Search Help!	
Social Sec	CIN #:				Below is the search Criteria with	o the Date of Service
	Last Name: First Name:				1.SSN (for e.g.: 999999999) 2.CIN (for e.g.: 9999999999) 3.Last Name AND First Name	
I	Date of Birth:				4.Last Name AND DOB (for e.g. I	DOB: 01/01/2015)
		Search Member Clear				
Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	Select

TAR Start & End Dates	s	
START DATE: 7/23/2025	END DATE: * 1/23/2026	TAR TYPE: * Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.
SELECT PROVIDER: *		Community Supports ~ SERVICE PROVIDER DETAILS:
SERVICE PROVIDER ADDRESS	S:	PROVIDER FAX# (ON FILE):
PREFERRED RETURN FAX#:		PATIENT CURRENT LOCATION: *
		Homeless 🗸
IS URGENT:		
No		~





PRIMARY DIAG	SNOSIS: * (No decimal point needed	d)	DIAG	DIAGNOSIS CODE:			DIAGNOSIS DESCRIPTION:			
Z5900				Z5900			Homelessness unspecified			
SECONDARY D	IAGNOSIS: (No decimal point need	SECO	NDARY CODE:		SECON	DARY DESCR	IPTION:			
Search diagnos	sis based on diagnosis code or its desc	ription								
			ier 1 Modifier 2 Modifier 3 U			_				
Service Code T2020	Service Description DAY HABIL WAIVER PER DIEM	Modifier 1 U6	Modifier 2	Modifier 3	Units 0	Quantity 1440	Charges 0	<i>₿</i> Edit	🛍 Delete	
	DAY HABIL WAIVER PER DIEM		Modifier 2	Modifier 3	0	1440	Ĩ	🖋 Edit	🛍 Delete	
T2020	DAY HABIL WAIVER PER DIEM		Modifier 2	Modifier 3	0		Ĩ	₽ Edit	û Delete	
T2020 Add New Service O	DAY HABIL WAIVER PER DIEM	06 NR will alw	<mark>ays</mark> have			1440 ttachments:	Ĩ		Delete	
T2020 Add New Service O	DAY HABIL WAIVER PER DIEM	06 NR will alw	<mark>ays</mark> have			1440 ttachments: Attachments: 0 :tach supporting d	0	re.	Payment is	





Medically Tailored Meals: Six months – End date will be six months from the start date for delivery delays. This service will be approved for 12 weeks only.

Submit the following:

PHC - eEligibility						•
Member Search		of Service will <u>alw</u> e start date of the				
	te of Service: urity Number:	7/23/2025			Search Help!	
					Below is the search Criteria with 1.SSN (for e.g.: 999999999)	
	First Name: Date of Birth:				2.CIN (for e.g.: 9999999999) 3.Last Name AND First Name 4.Last Name AND DOB (for e.g. [DOB: 01/01/2015)
	Date of Birth.	Search Member Clear				
Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	Select

START DATE:	END DATE: *	TAR TYPE: *
7/23/2025	1/23/2026	Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.
		Community Supports
SELECT PROVIDER: *		SERVICE PROVIDER DETAILS:
SERVICE PROVIDER ADD	RESS:	PROVIDER FAX# (ON FILE):
PREFERRED RETURN FAX	/#·	PATIENT CURRENT LOCATION: *
		Home
IS URGENT:		
No		





PRIMARY DIAGNOSIS: * (No decimal point needed)	DIAGNOSIS CODE:	DIAGNOSIS DESCRIPTION:
FRIMART DIAGNOSIS. (No decimal point needed)	DIAGNOSIS CODE.	DIAGNOSIS DESCRIPTION.
Z5948	Z5948	Other specified lack of adequate food
SECONDARY DIAGNOSIS: (No decimal point needed)	SECONDARY CODE:	SECONDARY DESCRIPTION:
Search diagnosis based on diagnosis code or its description		

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges		
S5170	HOME DEL, INCL PREP, PER MEL	U6			0	168	0	🖋 Edit	🛍 Delete
S9470	NUTRITIONAL COUNSELING, DIET	U6			0	6	0	🖋 Edit	🛍 Delete

Add New Service Code

A Community Supports (CS) TAR will *always* have a CS Referral Form attached via provider portal. Please ensure to also provide:

Condition and Criteria/Supporting Documents

Attachments:

Attachments: 0

Attach supporting documentation here.

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.





Sobering Centers: 1 day, 23:59 - End date will be the same as the start date

Submit the following:

PHC - eEligibility						
Member Search		of Service will <u>alway</u> e start date of the TA				
	te of Service:	7/23/2025			Search Help!	
Social Secu	CIN #:				Below is the search Criteria with	o the Date of Service
	Last Name: First Name:				1.SSN (for e.g.: 999999999) 2.CIN (for e.g.: 9999999999) 3.Last Name AND First Name	
I	Date of Birth:				4.Last Name AND DOB (for e.g. [DOB: 01/01/2015)
		Search Member Clear				
Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	Select

START DATE:	END DATE: *	TAR TYPE: *
7/23/2025	7/23/2025	Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.
		Community Supports
SELECT PROVIDER: *		SERVICE PROVIDER DETAILS:
SERVICE PROVIDER ADD	RESS:	PROVIDER FAX# (ON FILE):
PREFERRED RETURN FAX	#:	PATIENT CURRENT LOCATION: *
		Homeless
IS URGENT:		
No		~





PRIMARY DIAGNOSIS: * (No decimal point needed) Z5900			DIAGNOSIS CODE: Z5900			DIAGNOSIS DESCRIPTION: Homelessness unspecified				
SECONDARY DIAGNOSIS: (No decimal point needed) Search diagnosis based on diagnosis code or its description			SECONDARY C	ODE:	S	ECONDARY	DESCRIPT	ION:		
Service De	etails & Additional Notes	Modifier	r 1 Modifier 2	Modifier 3	Units	Quantity	Charges			
H0014	Alcohol and/or drug scvcs; ambulatory detoxification	U6	n mounter 2	Modifier 5	0	1	0	i €dit	🛍 Delet	
Add New Service	Code									
	nunity Supports (CS) TAR wil erral Form attached via provi				Attachi Attach s Disclaim	ments: 0 supporting docur er: Authorization o patient eligibilit	does not guarant	ee payment. P		

