Medical Treatment Authorization Request (TAR) Form

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
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To expedite your TAR request, please use our Provider Online Service Portal at https://provider.partnershiphp.org/UI/Login.aspx. If you don't currently have access to our Portal, please reach out to our Provider Education Team at esystemssupport@partnershiphp.org for assistance.

Provider Use Only

Rendering/Servicing Provider:_____

Rendering Phone Number:_____ Rendering Fax Number:_____

Servicing Address:_____ Group NPI:_____

City, State, Zip:_____ Tax ID:_____

☐ Outpatient (23 hours or less) ☐ Durable Medical Equipment ☐ Inpatient (24 hours or more)

The TAR is: If Inpatient, place of Service (POS):_____

☐ Urgent (72 hours) Potentially life-threatening condition Admit Date:_____

☐ Routine (Up to 5 business days): Important to health; not life threatening

Member Name:_____ Member CIN:_____

Address:_____ Date of Birth:_____

City, State, Zip:_____ Gender:_____

Diagnosis Description: ICD 10 CM Codes:

Medical Justification:

Services Requested	CPT Code/HCPC (Required)	Modifiers		Quantity	Charged

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:_____ Date:_____

Name/Title:_____

Requesting Dates of Service

Start Date:_____

End Date:_____

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