MEDI-CAL
TREATMENT AUTHORIZATION
REQUEST FORM (TAR)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
4665 Business Center Drive
Fairfield CA 94534
(707) 863-4133 or (800) 863-4144
FAX # (707) 863-4118
www.partnershiphp.org

PROVIDER USE ONLY

PROVIDER NAME:		PHONE NUMBER:	
FACILITY NAME:		FAX NUMBER:	
ADDRESS:		GROUP NPI:	
CITY, STATE, ZIP:		TAX ID:	

This TAR is: ☐ Urgent (72 hours): potentially life-threatening condition.

☐ Routine (Up to 5 business days): important to health; not life-threatening.

MEMBER NAME:
PRINT NAME: (FIRST, LAST)

ADDRESS:		MEMBER CIN:	
CITY:		DATE OF BIRTH:	
STATE, ZIP:		GENDER:	

DIAGNOSIS DESCRIPTION(S):

ICD-CM CODE(S):

MEDICAL JUSTIFICATION:

SERVICES REQUESTED:	CPT CODE/HCPCS:	MODIFIER(S):		QUANTITY:	CHARGES:

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 | NAME/ TITLE | DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

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.