



4665 Business Center Drive
Fairfield, California 94534
Fax (707) 863 - 4118

FAX

Date: _____

To: _____ From: _____

Fax: _____ Pages: # (including cover)

For Services Requested:

- Referral for BHT services for review Reference TAR # _____
- Clinical history/medical records (if applicable)
- *ROI = Release of Information

<u>For TAR Submission:</u>		
<input type="checkbox"/> BHT Assessment TAR	<input type="checkbox"/> Initial BHT services TAR	<input type="checkbox"/> Reauthorization for continuing BHT services TAR
<p>Please provide the following to ensure timely processing:</p> <ul style="list-style-type: none"> <input type="radio"/> Comprehensive Diagnostic Evaluation confirming ASD diagnosis <input type="radio"/> *ROI = Release of Information 	<p>Please provide the following to ensure timely processing:</p> <ul style="list-style-type: none"> <input type="radio"/> Copy of Treatment Plan (if requesting BHT treatment) <input type="radio"/> *ROI = Release of Information 	<p>Please provide the following to ensure timely processing:</p> <ul style="list-style-type: none"> <input type="radio"/> Copy of Treatment Plan with the progress of the goals / objectives <input type="radio"/> *ROI = Release of Information

*A copy of the ROI must be submitted with any request for BHT related services. Failure to submit a copy of the ROI may result in a delay of the authorization.

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