Medical Treatment Authorization Request (TAR) Form

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
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Fairfield CA 94534
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FAX # (707) 863-4118
www.ParttnershipHP.org

As a reminder to help expedite your TAR's faster, 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 Education Team at esystemssupport@partnershiphp.org to obtain access, or call (707) 863-4100 to request assistance.

Provider Use Only

Ordering Provider:_____ Rendering Provider:_____

Fax Number:_____ Rendering Phone Number:_____

Doctors NPI:_____ Rendering Fax Number:_____

Address:_____ Group NPI:_____

City, State, Zip:_____ Tax ID:_____

This TAR Service is: Place of Service (POS):_____

☐ Urgent (72 hours) Potentially Life-Threatening Condition Admin Date:_____

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

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

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 TAR 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.