PARTNERSHIP HEALTHPLAN of CALIFORNIA

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**

	For TAR Submission:	
☐ **BHT Assessment TAR**	☐ **Initial BHT servicesTAR**	☐ **Reauthorization for continuing BHT services TAR**
Please provide the following to ensure timely processing:	**Please provide the following to ensure timely processing:**	**Please provide the following to ensure timely processing:**
◯ **Comprehensive Diagnostic Evaluation confirming ASD diagnosis**	◯ **Copy of Treatment Plan (if requesting BHT treatment)**	◯ **Copy of Treatment Plan with the progress of the goals / objectives**
◯ ***ROI = Release of Information**	◯ ***ROI = Release of Information**	◯ ***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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