MEDI-CAL
TREATMENT AUTHORIZATION REQUEST FORM (TAR)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
4665 Business Center Drive
Fairfield CA 94534
(707) 863-4414 or (800) 863-4155
FAX # (707) 863-4330
www.partnershiphp.org

(PLEASE TYPE) **(FOR PROVIDER USE)** **(PLEASE TYPE)**

REQUEST IS RETROACTIVE ? YES ☐ NO ☐

PROVIDER PHONE NO. ( )

FAX # ( )

PROVIDER NPI#

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS

PATIENTS AUTHORIZED REPRESENTATIVE (IF ANY)
ENTER NAME AND ADDRESS:

NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.)

PATIENT IDENTIFICATION NO.

STREET ADDRESS

SEX

AGE

DATE OF BIRTH M M D D Y Y

CITY, STATE, ZIP CODE

HOME ☐ BOARD & CARE ☐ SNF/ICF ☐ ACUTE HOSPITAL ☐

PHONE NUMBER
AREA
( )

DIAGNOSIS DESCRIPTION:

CURRENT ICD-10CM CODE

MEDICAL JUSTIFICATION:

FOR PHC USE ONLY

PROVIDER: YOUR REQUEST IS:

APPROVED AS REQUETED ☐ DENIED ☐ DEFERRED ☐

APPROVED AS MODIFIED ☐

BY: _____
PHC CONSULTANT'S NAME

DATE M M D D Y Y

REVIEW COMMENT INDICATOR ☐

COMMENTS / EXPLANATION

LINE NO.	AUTHORIZED YES	AUTHORIZED NO	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC / UPC OR PROCEDURE CODE	QUANTITY	CHARGES
1								
2								
3								
4								
5								
6								

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 | TITLE | DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

FROM DATE M M D D Y Y

TO DATE M M D D Y Y

TAR CONTROL NUMBER

OFFICE | SEQUENCE NUMBER | PI

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