

MEDI-CAL TREATMENT AUTHORIZATION **REQUEST FORM (TAR)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
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(PLEASE TYPE)	(FOR PROVIDER USE)	(PLEASE TYPE)	
	REQUEST IS RETROACTIVE ? YES NO	PROVIDER PHONE NO.	PATIENTS AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:
PROVIDER NAME AND A PLEASE TYPE YOUR	DDRESS	FAX#	· ·
NAME AND ADDRESS HERE		PROVIDER NPI#	FOR PHC USE ONLY PROVIDER: YOUR REQUEST IS: APPROVED AS REQUETED DENIED DEFERRED
NAME AND ADDRESS OF PATIENT PATIENT NAME (LAST, FIRST, M.I.)	PATIENT IDEN	ITIFICATION NO.	APPROVED AS MODIFIED BY: PHC CONSULTANT'S NAME
STREET ADDRESS	SEX AGE	DATE OF BIRTH	DATE REVIEW COMMENT INDICATOR
CITY, STATE, ZIP CODE	НОМЕ	BOARD & CARE	COMMENTS / EXPLANATION
PHONE NUMBER AREA () DIAGNOSIS DESCRIPTION:	CURRENT I	ACUTE HOSPITAL	
MEDICAL JUSTIFICATION:			
LINE AUTHORIZED APPROVED NO. YES NO UNITS	SPECIFIC SERVICES REQUESTED		IDC / UPC OR 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			AUTHORIZATION IS VALID FOR SERVICES PROVIDED
TO THE HEALTH OF THE PATIENT.		ММ	FROM DATE TO DATE M M D D Y Y TAR CONTROL NUMBER
SIGNATURE OF PHYSICIAN OR PROVIDER	TITLE	DATE OFFICE	SEQUENCE NUMBER PI