



Instructions for Completing Fee-For-Service Provider – Outpatient Treatment Authorization Request (TAR)

Either **TYPE** or **PRINT** form. If printing, please write **LEGIBLY**. All areas must be completed. **DO NOT LEAVE BLANKS**. Incomplete TARs will not be reviewed.

Part 1: Beneficiary Information. Please complete:

PART 1		BENEFICIARY INFORMATION		
Client Name		DOB	_ / _ / _	
Phone		SSN or <u>Medi-Cal</u> Number		
Address				
City		Zip Code		
Living Arrangement	<input type="checkbox"/> Independent <input type="checkbox"/> Bio Family <input type="checkbox"/> Foster Family <input type="checkbox"/> Group Home <input type="checkbox"/> SNF <input type="checkbox"/> B&C			
Minor is under the jurisdiction of:	<input type="checkbox"/> DCS <input type="checkbox"/> Court <input type="checkbox"/> Probation <input type="checkbox"/> Bio Family <input type="checkbox"/> Other:			

- Client name
- Date of Birth
- Phone Number
- Social Security Number or Medi-Cal Number
- Address
- City and Zip Code
- Living arrangement - please check one box.
- Minor is under the jurisdiction of - please check box if applicable, otherwise mark "other" and write in "n/a"

Part 2: Provider Information. Please complete:

PART 2		PROVIDER INFORMATION		
Provider Name				
Provider Service Site Address			Phone #	
City		Zip Code	Fax #	
Licensure	<input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> LCSW <input type="checkbox"/> LMFT			

- Provider Name
- Provider Service Site Address (must be an approved service site)
- City & Zip Code
- Phone Number
- Fax Number
- Licensure – Please check appropriate box

Part 3: Treatment Authorization Requested. Please complete:

PART 3		TREATMENT AUTHORIZATION REQUESTED <i>(check all that apply)</i>	
<input type="checkbox"/> Adult <input type="checkbox"/> Minor	<input type="checkbox"/> Initial Authorization Assessment Date ___/___/___ <i>(90791 or 90792 Claims)</i>	<input type="checkbox"/> Re-Authorization <i>or</i> <input type="checkbox"/> Changes to Authorization	Received Date Stamp <i>(County Use Only):</i>
Coordination of Care with		<input type="checkbox"/> PCP <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> LCSW <input type="checkbox"/> LMFT <input type="checkbox"/> DCFS <input type="checkbox"/> Other:	
Modality & Requested Units <i>(For Psychologist, LCSW, LMFT)</i>		<input type="checkbox"/> Individual _____ <input type="checkbox"/> Family _____ <input type="checkbox"/> Case Conference _____ <input type="checkbox"/> Group _____ <i>* If this is a Change to Authorization, describe the Clinically Significant Event necessitating the additional session(s).</i> <i>* Authorizations are for 6 month cycles.</i>	
Modality & Requested Units <i>(For Psychiatrist)</i>		<input type="checkbox"/> Pharmacological Management # Requested _____ <i>* If this is a Change to Authorization, describe the Clinically Significant Event necessitating the additional session(s).</i> <i>* Authorizations for minors are for 6 month cycles.</i> <i>* Authorizations for adults are for 12 month cycles.</i>	*NOTE: Signed Medication Consent Form MUST be attached for Initial and/or Re-Authorization Requests.

- Please mark ONE box for “adult” or “minor”
- Please mark “YES” box if minor has an active CFS case. Otherwise, please mark “NO”.
- Initial Authorization Assessment Date. This is the date of the assessment. Claims for 90791 or 90792 will be based on this date. If this is not an initial authorization, go to next box.
- Please mark if this is a Re-Authorization or a Change to Authorization.
- DO NOT MARK in the space labeled Received Date Stamp. This is for county use only. This is the date authorization will begin if TAR is approved.
- Coordination of Care with – please check the box of PCP, Psychiatrist, Psychologist, LCSW, LMFT, DCFS, etc. that beneficiary may be working with that you may coordinate the client’s care with.
- Psychologists, LCSW, LMFT – Modality & Requested Units – Please check the box next to the preferred modality. In the space next to this modality write in the number of sessions requested. Please note that authorizations are for a **6 MONTH** cycle. More than one modality may be chosen. Please see the provider manual for further information regarding modalities and number of sessions requested.
- Psychiatrists – Please check the box for Pharmacological Management. Please note that authorizations for MINORS are for a 6 MONTH cycle, and for ADULTS are for a 12 MONTH cycle. Also NOTE that the SIGNED Medication Consent Form MUST BE ATTACHED for Initial Requests and Re-Authorization Requests. TAR will not be reviewed without this form.
- Changes to Authorization- please mark “Changes to Authorization” if you need additional sessions during the current authorization period. Please only request the number of sessions needed **in addition to** the sessions you have already been authorized for that time period (i.e., you have an authorization with 13 sessions for a 6 month authorization period. Two months into treatment, the beneficiary is hospitalized. You now decide that weekly sessions are required in order to stabilize beneficiary. The change to authorization will reflect the number of sessions in excess of the 13 sessions already authorized).

Part 4: Medical Necessity:

PART 4		Medical Necessity for Tier III Services is met: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Current Risk Assessments	Suicidal Ideation	<input type="checkbox"/> None Describe:	<input type="checkbox"/> Ideation	<input type="checkbox"/> Intent	<input type="checkbox"/> Plan	<input type="checkbox"/> Means	<input type="checkbox"/> History
	Homicidal Ideation	<input type="checkbox"/> None Describe:	<input type="checkbox"/> Ideation	<input type="checkbox"/> Intent	<input type="checkbox"/> Plan	<input type="checkbox"/> Means	<input type="checkbox"/> History
Inpatient Psychiatric Admissions <input type="checkbox"/> None or <input type="checkbox"/> Yes if yes, Total #: ____ # In Past Year: ____ Date of 1 st : __ / __ / ____ Date of Last : __ / __ / ____				Other Outpatient Mental Health Services <input type="checkbox"/> None <input type="checkbox"/> Yes If yes, type of Service: _____			

- Risk Assessments – Suicidal/Homicidal Ideations – Please mark one box for each. If you mark any box other than “None”, you MUST provide further details.
- Prior Inpatient Psychiatric Admissions – Please mark one box. If you mark “YES” please include how many hospitalizations beneficiary has had in the past year ONLY.
- Other Outpatient Mental Health Services – Please mark one box. If you mark “YES” please include dates and location of prior treatment.

CURRENT DIAGNOSIS: MUST USE ICD-10-CM CODE.

CURRENT DIAGNOSES	
ICD-10 Code	Name *(Diagnosis name must match with the reported code) **Must document Specific, Behavioral Examples of the Diagnostic Symptoms including Frequency and Severity:

- Please write out entire name of diagnosis and please make sure the name matches the code.
- Please provide SPECIFIC clinical symptoms and behaviors that support your diagnosis. (ie. symptoms of depression including sad mood, lack of sleep, too much sleep, poor appetite, suicidal ideations, etc.. please do not simply put “Depression”). Also provide timelines for presenting problems.

**You Must Provide behaviorally specific examples of the selected impairment(s):		
Describe or Indicate N/A	Primary Support	<input type="checkbox"/> N/A
	Social Environment	<input type="checkbox"/> N/A
	Educational	<input type="checkbox"/> N/A
	Occupational	<input type="checkbox"/> N/A
	Housing	<input type="checkbox"/> N/A
	Economic	<input type="checkbox"/> N/A
	Legal	<input type="checkbox"/> N/A
	Access to Health Care Services	<input type="checkbox"/> N/A
	Other Psychosocial /Environmental	<input type="checkbox"/> N/A

- Please provide behaviorally specific examples for each of the areas of impairment. Please mark “N/A” if there is no impairment in that area.

Re-Authorizations:

REQUIRED ADDITIONAL INFORMATION FOR RE-AUTHORIZATIONS: <i>**Describe how treatment benefitted the client. Identify improvements or barriers in treatment. Be behaviorally and symptom specific:</i>		
_____ (Symptoms / Behaviors)	Severity (increased, decreased, or the same)	Frequency (/hr, /day, /wk, /mo)
_____ (Symptoms / Behaviors)	Severity (increased, decreased, or the same)	Frequency (/hr, /day, /wk, /mo)
_____ (Symptoms / Behaviors)	Severity (increased, decreased, or the same)	Frequency (/hr, /day, /wk, /mo)
_____ (Symptoms / Behaviors)	Severity (increased, decreased, or the same)	Frequency (/hr, /day, /wk, /mo)

****If barriers are identified, please describe:**

- Describe how the client has benefitted from treatment. Be specific when describing symptoms and behaviors.
- If there are any barriers to treatment that have been identified, please describe.

Medical:

Current Medical Conditions:	Health Problems	<input type="checkbox"/> None <input type="checkbox"/> Yes / Describe:
	Sleep Problems	<input type="checkbox"/> None <input type="checkbox"/> Yes / Describe:
	Appetite Problems/Changes	<input type="checkbox"/> None <input type="checkbox"/> Yes / Describe:
	Adverse Response to Medications	<input type="checkbox"/> None Known <input type="checkbox"/> Yes / Describe:
Required for Minors	Height:	Problems / Changes:
	Weight:	Problems / Changes:

- Medical Conditions – Please mark one box for each category. If you mark “YES” please provide a brief explanation. Please do not mark “YES” and leave description blank. Height and weight are REQUIRED for minors and only required for TARS submitted by Psychiatrists. Please note any changes in height or weight such as a gain or loss.

Medications:

Current Medications /Prescribed During This Visit:	Name	Dose	Frequency	Target Symptoms

Past Psychotropic Medications - including current medications if taken before this visit:

- Current medication – Please list all medications, dose, frequency and target symptoms. If none, please write “n/a”. If dosage or other information is not known, please write “unknown”, Do not leave blank.
- Past Medications – please list all known previous medications. If none, please write “n/a”.

Documentation Tool:

<p>*Tool for your Convenience - Sample (TAR) Documentation</p> <p style="text-align: center;"><u>Initial TAR</u></p> <p>Example: Dx: Depression Sx/Bx: depressed 7/10 with 10 the worst, crying spells whenever alone and sometimes while with others, isolates to bedroom daily, sleeps 3h/night and 10h/day, poor focus, energy and motivation, not socializing, sad, h/o cutting, thoughts of SI 2x/mo but no plan.</p> <p style="text-align: center;"><u>Re-Auth TAR</u></p> <p>Example: Dx: ADHD; Sx/Bx: less impulsive and hyperactive, better able to sit still, calmer, focus is better, needs redirection now only 2x/day, able to stay on task better and more goals, school grades now Cs and Bs.</p>

Reminder Tool: Please review each item and make sure you have completed each one.

<p><u>Reminder Tool</u></p> <p><input type="checkbox"/> Did I attach the completed Medication Consent form with the ‘Initial’ and/or ‘Re-Authorization’ TAR? <i>(Psychiatrists Only)</i></p> <p><input type="checkbox"/> Did I include the Initial Authorization Assessment Date with the ‘Initial’ TAR?</p> <p><input type="checkbox"/> Does the ‘Provider Service Site Address’ match the service site address given previously for this patient?</p> <p><input type="checkbox"/> Did I include current and correct patient identification information?</p>
--

Part 5: Provider Name and Signature: Please PRINT name, Sign and Date. ANY Missing information will result in TAR not being reviewed.

PART 5	PROVIDER NAME & SIGNATURE		
	I certify that the above information is accurate and all the eligibility documentation required are on file.		
Provider Name		Provider Signature	Date

FAX COMPLETED FORM TO COUNTY OF SAN BERNARDINO ACCESS UNIT AT (909) 890-0353.
 Authorization requests are processed within 14 calendar days from date this completed TAR is received by the unit.

Do Not Write below the signature line. Access Unit Use only beyond this point.

PART 6	MHP ACTION: (COUNTY USE ONLY)		
<input type="checkbox"/> Unable to Process	<input type="checkbox"/> Missing required information	<input type="checkbox"/> Unable to locate beneficiary	<input type="checkbox"/> Duplication of services
	<input type="checkbox"/> Other: _____		
Action	<input type="checkbox"/> Approved (<i>Authorization letter sent</i>)	<input type="checkbox"/> Modified	<input type="checkbox"/> NOA-B
	<input type="checkbox"/> 14 Days Extension Request Made.	<input type="checkbox"/> Denied	Issued
	Extension: _____ =28 days from original stamp date		<input type="checkbox"/> Provider Notified _ _ _
			<input type="checkbox"/> Beneficiary Notified _ _ _
Reason for 14 Days Extension or Comments			
Access Unit Reviewer Name		Signature	
Reviewer Title / License		Date	