HealthPlan OF SAN MATEO

701 Gateway Blvd., Suite 400, South San Francisco, CA 94080
TEL: 650-616-0050 • FAX: 650-829-2079 • TTY: 1-800-735-2929

ACE

TAR-OUTPATIENT (50-1)

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

Verbal Control No.

Type Of Service Requested ☐ Drug ☐ Other

Request Is Retroactive? ☐ Yes ☐ No

Provider Phone No.

Provider Fax No.

NPI Number(s)*

PROVIDER NAME AND ADDRESS

•
•
•
•

(PLEASE TYPE)

Patient's Authorized Representative (If Any)
Enter Name and Address:

•
•

FOR HPSM USE

Provider, Your Request is:

☐ APPROVED AS REQUESTED
☐ DENIED
☐ DEFERRED
☐ APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)

REVIEWER

I.D. # DATE (MM/DD/YY) / /

☐ REVIEW COMMENT INDICATOR

COMMENTS/EXPLANATION

Name And Address Of Patient

Last First M.I.

Street address

City State Zip Code

Phone Number SMMC MR#

SMMC Account Number SMMC Type of Service

ACE Identification No.

Sex Age Date of Birth

Patient Status

☐ Home ☐ Board & Care
☐ SNF/ICF ☐ Acute Hospital

ICD9 Code

Diagnosis Description:

Medical Justification:

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	☐	☐						
7	☐	☐						
8	☐	☐						
9	☐	☐						
10	☐	☐						

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 (MM/DD/YY) / / To Date (MM/DD/YY) / /

TAR Control Number

Office Sequence Number PI

FOR QUESTIONS ON THIS REQUEST, PLEASE CALL HPSM HEALTH SERVICES AT 650-616-2070. **NOTE**: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE ID CARD IS CURRENT BEFORE RENDERING SERVICE.