

TAR-OUTPATIENT (50-1)

(PLEASE TYPE)	(FOR PROVIDER USE)	(PLEASE TYPE)
Verbal Control No. <input type="text"/> Type Of Service Requested <input type="checkbox"/> Drug <input type="checkbox"/> Other	Request Is Retroactive? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient's Authorized Representative (If Any) Enter Name and Address:
PROVIDER NAME AND ADDRESS • _____ • _____ • _____ • _____	Provider Phone No. <input type="text"/> Provider Fax No. <input type="text"/> NPI Number(s)* _____	• _____ • _____
FOR HPSM USE		
Provider, Your Request is:		
<input type="checkbox"/> APPROVED AS REQUESTED <input type="checkbox"/> DENIED <input type="checkbox"/> DEFERRED <input type="checkbox"/> APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)		

Name And Address Of Patient			CA Identification No.		
Last <input type="text"/>	First <input type="text"/>	M.I. <input type="text"/>	<input type="text"/>		
Street address <input type="text"/>			Sex <input type="text"/>	Age <input type="text"/>	Date of Birth <input type="text"/>
City <input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/>	Patient Status		
Phone Number <input type="text"/>	ICD9 Code <input type="text"/>		<input type="checkbox"/> Home	<input type="checkbox"/> Board & Care	
SMMC Account Number <input type="text"/>	SMMC Medical Record Number <input type="text"/>		<input type="checkbox"/> SNF/ICF	<input type="checkbox"/> Acute Hospital	
Diagnosis Description:			Type of Service <input type="text"/>		
Medical Justification:					

REVIEWER <input type="text"/>		
I.D. # <input type="text"/>	DATE (MM/DD/YY) <input type="text"/>	
<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>						
2	<input type="checkbox"/>	<input type="checkbox"/>						
3	<input type="checkbox"/>	<input type="checkbox"/>						
4	<input type="checkbox"/>	<input type="checkbox"/>						
5	<input type="checkbox"/>	<input type="checkbox"/>						
6	<input type="checkbox"/>	<input type="checkbox"/>						
7	<input type="checkbox"/>	<input type="checkbox"/>						
8	<input type="checkbox"/>	<input type="checkbox"/>						
9	<input type="checkbox"/>	<input type="checkbox"/>						
10	<input type="checkbox"/>	<input type="checkbox"/>						

<p>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.</p> <p>Signature of Physician or Provider _____ Title _____ Date _____</p>	<p>Authorization Is Valid For Services Provided</p> <p>From Date (MM/DD/YY) <input type="text"/> / <input type="text"/> / <input type="text"/> To Date (MM/DD/YY) <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>TAR Control Number</p> <p>Office <input type="text"/> Sequence Number <input type="text"/> PI <input type="text"/></p>
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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.