

TAR-Inpatient (18-1)

Admit Number (Original Authorization Number)	Admit Date (MM/DD/YY)	Auth. Exp (MM/DD/YY)	Emer Admit <input type="checkbox"/>	Verbal Control	Patient ID No.	Sex	Date of Birth (MM/DD/YY)	Age
<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NPI Number(s)					Patient Name			
<input type="text"/>					<input type="text"/>			
Provider Phone No.			Provider Fax No.		Number of Days Requested		Type of days	Retroactive
<input type="text"/>			<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>
Provider Name					Discharge Date (MM/DD/YY)			
<input type="text"/>					<input type="text"/>			
Provider Street / Mailing Address					Admitting ICD9-CM			
<input type="text"/>					<input type="text"/>			
City		State		Zip Code		Admitting Diagnosis Description		
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		
Patient Account Number			Patient Medical Record Number		Type of Service			
<input type="text"/>			<input type="text"/>		<input type="text"/>			

FOR PHYSICIAN—PLEASE PROVIDE SUFFICIENT ESSENTIAL DETAIL TO PERMIT A REASONABLE EVALUATION OF THE LENGTH AND LEVEL OF CARE REQUESTED.

Current Diagnosis	Current ICD9-CM Code	Patient's Authorized Representative (If Any) Enter Name And Address
<input type="text"/>	<input type="text"/>	<input type="text"/>
Describe current condition requiring extension. Include pertinent lab and x-ray reports with dates. (Attach clinical notes)		
<input type="text"/>		
<input type="text"/>		
<input type="text"/>		

List the procedures that will require an extension of this hospital stay. Include dates when possible.

<input type="text"/>
<input type="text"/>
<input type="text"/>

<p>HOSPITAL: To the best of my knowledge the above information is true, accurate and complete and the requested services are medically indicated necessary to the health of the patient.</p>	Type Or Print Name Of Responsible Physician	Signature of Responsible Physician
<input type="text"/>	<input type="text"/>	<input type="text"/>
Signature of Provider	Date (MM/DD/YY)	Signature of Provider
<input type="text"/>	<input type="text"/>	<input type="text"/>

Validating Information And Explanation	<p align="center">FOR HPSM USE ONLY</p> <p> <input type="checkbox"/> Denied <input type="checkbox"/> Approved As Requested From (MM/DD/YY) <input type="text"/> / <input type="text"/> / <input type="text"/> </p> <p> <input type="checkbox"/> Deferred <input type="checkbox"/> Approved As Modified Thru (MM/DD/YY) <input type="text"/> / <input type="text"/> / <input type="text"/> </p> <p align="right"> <input type="text"/> Days <input type="text"/> Acute </p> <p align="center">Dates of Days Denied (MM/DD)</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </p> <p>Days of the Hospitalization are Denied (See Comments)</p> <p> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </p>
Chart Reviews	Review Comments Indicator
<input type="checkbox"/>	<input type="checkbox"/>

Reviewed By	ID No.	Date (MM/DD/YY)	TAR Control Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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.