

## TAR-OUTPATIENT (50-1)

<b>(PLEASE TYPE)</b> 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	<b>(FOR PROVIDER USE)</b> Provider Phone No. <input type="text"/> Provider Fax No. <input type="text"/> NPI Number(s)* <input type="text"/>	<b>(PLEASE TYPE)</b> Patient's Authorized Representative (If Any) Enter Name and Address: _____ _____ _____
<b>PROVIDER NAME AND ADDRESS</b> _____ _____ _____ _____		<b>FOR HPSM USE</b> 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 Last <input type="text"/> First <input type="text"/> M.I. <input type="text"/> Street address <input type="text"/> City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/> Phone Number <input type="text"/> SMMC MR# <input type="text"/> SMMC Account Number <input type="text"/> SMMC Type of Service <input type="text"/>	HF Identification No. <input type="text"/> Sex <input type="text"/> Age <input type="text"/> Date of Birth <input type="text"/> Patient Status <input type="checkbox"/> Home <input type="checkbox"/> Board & Care <input type="checkbox"/> SNF/ICF <input type="checkbox"/> Acute Hospital	ICD9 Code <input type="text"/> Diagnosis Description: _____ 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><b>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.</b></p> Signature of Physician or Provider _____ Title _____ Date _____	Authorization Is Valid For Services Provided 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"/> TAR Control Number <input type="text"/> Office <input type="text"/> Sequence Number <input type="text"/> PI <input type="text"/>
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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.