

**TAR-Inpatient (18-1)**

Admit Number (Original Authorization Number)	Admit Date (MM/DD/YY)	Auth. Exp (MM/DD/YY)	Emer Admit	Verbal Control	Patient ID No.	Sex	Date of Birth (MM/DD/YY)	Age
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<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.

  
  


<b>HOSPITAL:</b> 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.	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	<b>FOR HPSM USE ONLY</b>
<input type="text"/>	<input type="checkbox"/> Denied <input type="checkbox"/> Approved As Requested    From (MM/DD/YY) <input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="checkbox"/> Deferred <input type="checkbox"/> Approved As Modified    Thru (MM/DD/YY) <input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/> Days <input type="text"/> Acute
<input type="text"/>	Dates of Days Denied (MM/DD)
<input type="text"/>	Days of the Hospitalization are Denied (See Comments)
<input type="text"/>	<input type="text"/>

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.