

STATE USE ONLY

1

**CONFIDENTIAL PATIENT INFORMATION**

FOR F.I. USE ONLY

1A

CCN

**TREATMENT AUTHORIZATION REQUEST**

STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

F.I. USE ONLY

40  41

42  43

43

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4

TYPEWRITER ALIGNMENT

Elite Pica

TYPEWRITER ALIGNMENT

Elite Pica

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**FOR PROVIDER USE**

1B

VERBAL CONTROL NO.

2 TYPE OF SERVICE REQUESTED:  DRUG  OTHER

3 PROVIDER NAME AND ADDRESS

3 PROVIDER NUMBER

4 PATIENT NAME (LAST, FIRST, M.I.)

5 CAL IDENTIFICATION NUMBER

7 SEX  M  F

8 AGE  DATE OF BIRTH

8A HOME BOARD & CARE

8B SNF/ICF ACUTE HOSPITAL

8C MEDICAL JUSTIFICATION:

2A PROVIDER PHONE NO.

6

7

8

8A

8B

8C

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS

32A

33 FOR STATE USE

PROVIDER, YOUR REQUEST IS:

1  APPROVED

2  APPROVED AS MODIFIED (REVISIONS LISTED BELOW AS AUTHORIZED MAY BE CLAIMED)

DENIED  DEFERRED

JACKSON VS RANK PARAGRAPH COE

BY: \_\_\_\_\_ MEDICAL CONSULTANT REVIEW COMMENTS INDICATOR

34 I.D. #  35 DATE  44

COMMENTS/EXPLANATION

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DIAGNOSIS DESCRIPTION:

ICD 9 CM DIAGNOSIS CODE

RETROACTIVE AUTHORIZATION OF

36 1  2  3

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#	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPC OR PROCEDURE CODE	QUANTITY	CHARGES
9	13	10	10A	10B	11
2				12	12A
3				16	\$
4				19	\$
5				23	\$
6				27	\$
7				28	\$
8				32	\$
9				37	\$
10				38	\$

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NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE. SEND TO FIELD SERVICES (F.I. COPY)

SIGNATURE OF PHYSICIAN OR PROVIDER \_\_\_\_\_ TITLE \_\_\_\_\_ DATE \_\_\_\_\_

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

37 FROM DATE  38 TO DATE

TAR CONTROL NUMBER

SEQUENCE NUMBER 50-1-0902 PI

17271453

Figure 1. Sample of a Treatment Authorization Request Form (50-1).

2 – TAR Completion

September 1999