COUNTY OF MARIN

Behavioral Health and Recovery Services
Department of Health and Human Services

Treatment Authorization Request (TAR) for Residential Substance Use Treatment (Adult)

Continuing and Extension Authorization

To Be Completed by Requesting Provider:

Name of Client: _____ **DOB**_____

Client Mailing Address: _____

Marin County Resident? ☐ Yes ☐ No

Client is currently Pregnant? ☐ Yes ☐ No **Client has given birth in the last 60 days?** ☐ Yes ☐ No

Client Consent Obtained for Marin County to Mail NOABD, if Applicable? ☐ Yes ☐ No

Client Insurance Status: ☐ Medi-Cal Beneficiary: _____ ☐ Uninsured ☐ Other: _____
(Medi-Cal ID Number)

Agency/Program for Which Client Would Receive Treatment:

☐ BI-BETT (Diablo Valley Ranch)
☐ BI-BETT (Shamia)
☐ Buckelew (Helen Vine)
☐ Center Point (Manor)
☐ Center Point (Village)
☐ El Chante
☐ HealthRIGHT 360
☐ Waterfront Recovery Services
☐ Women's Recovery Services
☐ Other: _____

Expiration Date for the Current Authorization: _____ ***Current Authorization Expiration Date can be located in WITs*

Date Requesting Continuing or Extension Authorization: _____

Note: that requests for Continuing and Extension Authorization should be submitted at least seven (7) calendar days before the expiration of the current authorization.

ASAM Level of Care Requesting: ☐ ASAM 3.1 ☐ ASAM 3.3 ☐ ASAM 3.5 ☐ Other: _____

Length of Authorization Requesting: (Check only one)

☐ Continuing Authorization (46 – 90 days, up to 45 days) ☐ Extension Authorization (90+ days, up to 30 days at a time)

Note: If approved, the approved dates will be added to the client's previous authorization. For questions regarding authorized dates/timeframes, contact your Contract Manager.

DSM Diagnosis(es): _____ **ICD-10 Code(s)**: _____

DSM V Diagnosis: Must at least include a diagnosis of substance-related and addictive disorders with the exception of tobacco-related disorders

Justification for Continued or Extension Authorization: _____

_____

_____

To the best of my knowledge, the above information is true, accurate and complete and the requested service meets the DMC-ODS STCs and ASAM Criteria definitions of medical necessity for the requested level of care. The determination of medical necessity indicates that the services requested are required to identify and treat the diagnosed condition and that treatment services are consistent with the diagnosis and treatment of the condition and the standards of good medical practice.

_____ _____ _____

Signature of Medical Director/LPHA *Printed Name of Medical Director/LPHA* *Date*

Providers must submit this form and the completed ASAM Re-Assessment via either encrypted email to BHRSAuthSUS@marincounty.org or by Faxing to (415) 634-1651.

To Be Completed by Marin County BHRS:

Date/Time TAR Received: _____@____: ____ ☐AM ☐PM **Date/Time TAR Review Completed**: _____@____:____ ☐AM ☐PM

TAR Response: ☐ Approved ☐ Pending* ☐ Denied *If Denied*, was a NOABD Issued: ☐ Yes ☐ No

**Providers must respond to Pending TARs within 24 hours. Failure to respond within timeframes outlined will result in the TAR being Denied.*

Comments/Explanation: _____

_____

_____ _____ _____

Signature of BHRS TAR Reviewer *Printed Name of BHRS TAR Reviewer* *Date*