

Treatment Authorization Request (TAR) for Residential Substance Use Treatment (Adult)**Initial Authorization****To Be Completed by Requesting Provider:**

Name of Client: _____ DOB _____

Client Mailing Address: _____

Marin County Resident? Yes NoClient is currently Pregnant? Yes No Client has given birth in the last 60 days? Yes NoClient Consent Obtained for Marin County to Mail NOABD, if Applicable? Yes NoClient Insurance Status: Medi-Cal Beneficiary: _____ (Medi-Cal ID Number)
 Uninsured Other: _____**Agency/Program for Which Client Would Receive Treatment:** BI-BETT (Diablo Valley Ranch) Center Point (Manor) HealthRIGHT 360 BI-BETT (Shamia) Center Point (Village) Waterfront Recovery Services Buckelew (Helen Vine) El Chante Women's Recovery Services Other: _____

For Out-of-County Placement Only: Date of Referral: _____ Date of Initial Contact: _____

Proposed Admission Date: _____

*Note: Prior Authorization should be submitted at least 24 hours before the proposed admission date and must be requested prior to the admission of the client.*ASAM Level of Care Requesting: ASAM 3.1 ASAM 3.3 ASAM 3.5 Other: _____Length of Authorization Requesting: Initial Authorization (1 – 45 days)*Note: If Approved, the Authorization does not guarantee payment. Payment is subject to a client's eligibility for County-contracted services and services being rendered and documented in accordance with DMC-ODS STCs and other Federal, State and County regulations and policies.*

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 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, the completed ASAM Assessment and Medi-Cal Verification 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 PMTAR 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