COUNTY OF MARIN

Behavioral Health and Recovery Services
Department of Health and Human Services

Treatment Authorization Request (TAR) for Residential Substance Use Treatment

Initial 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)	☐ Center Point (Manor)	☐ HealthRIGHT 360
☐ BI-BETT (Shamia)	☐ Center Point (Village)	☐ Waterfront Recovery Services
☐ Buckelew (Helen Vine)	☐ El Chante	☐ Women's Recovery Services
☐ Advent Group Ministries (St. John)	☐ Advent Group Ministries (Summit)	☐ 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 for Adults and 1-30 days for Adolescents)

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 ☐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*