

**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  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:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> BI-BETT (Diablo Valley Ranch) | <input type="checkbox"/> Center Point (Manor)   | <input type="checkbox"/> HealthRIGHT 360              |
| <input type="checkbox"/> BI-BETT (Wollam)              | <input type="checkbox"/> Center Point (Village) | <input type="checkbox"/> Waterfront Recovery Services |
| <input type="checkbox"/> Buckelew (Helen Vine)         | <input type="checkbox"/> El Chante              | <input type="checkbox"/> Women's Recovery Services    |
| <input type="checkbox"/> 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](mailto: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