

Treatment Authorization Request (TAR) for Residential Substance Use Treatment**Continuing and Extension 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: _____ Uninsured Other: _____
(Medi-Cal ID Number)**Agency/Program for Which Client Would Receive Treatment:**

- | | | |
|--|---|---|
| <input type="checkbox"/> BI-BETT (Diablo Valley Ranch) | <input type="checkbox"/> Camp Recovery (Adolescent) | <input type="checkbox"/> HealthRIGHT 360 |
| <input type="checkbox"/> BI-BETT (Wollam) | <input type="checkbox"/> Center Point (Manor) | <input type="checkbox"/> Waterfront Recovery Services |
| <input type="checkbox"/> BI-BETT (Pueblos del Sol) | <input type="checkbox"/> Center Point (Village) | <input type="checkbox"/> Women's Recovery Services |
| <input type="checkbox"/> Buckelew (Helen Vine) | | |

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 for adults / 31-60 days, up to 30 days for adolescents)
- Extension Authorization (90+ days for adults 60+ days for adolescents, 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 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