

**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"/> Buckelew (Helen Vine)  | <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    |

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.gov](mailto:BHRSAUTHSUS@marincounty.gov) 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