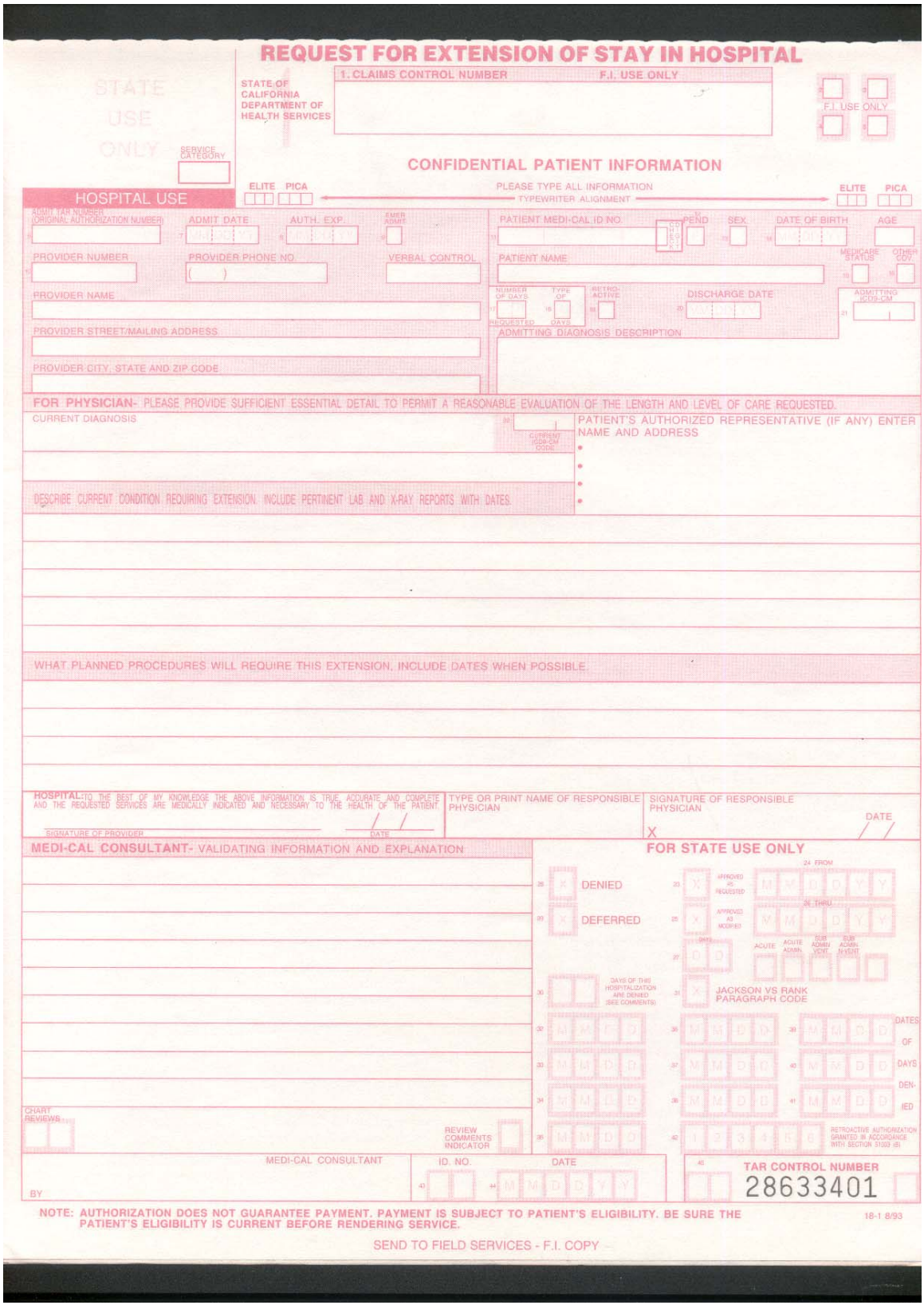
Appendix I: TAR Forms

TAR forms include:

- (Hospital) Extension-of-Stay (18-1) TAR for hospital stays;
- Long-term care (20-1) TAR for nursing home stays;
- Treatment Authorization Request (50-1) for medical procedures and pharmacy; and
- Discharge Planning Option (55-1) TAR for coordinated requests for a beneficiary being discharged.



REQUEST FOR EXTENSION OF STAY IN HOSPITAL

STATE USE ONLY

SERVICE CATEGORY

STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

1. CLAIMS CONTROL NUMBER — F.I. USE ONLY

F.I. USE ONLY

CONFIDENTIAL PATIENT INFORMATION

HOSPITAL USE

ELITE PICA

PLEASE TYPE ALL INFORMATION — TYPEWRITER ALIGNMENT

ELITE PICA

ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER) | ADMIT DATE | AUTH. EXP. | EMER ADMIT

PATIENT MEDI-CAL ID NO. | PERSON CODE | PEND | SEX | DATE OF BIRTH | AGE

PROVIDER NUMBER | PROVIDER PHONE NO. | VERBAL CONTROL

PATIENT NAME | MEDICARE STATUS | OTHER COV.

PROVIDER NAME

NUMBER OF DAYS REQUESTED | TYPE OF DAYS | RETRO-ACTIVE | DISCHARGE DATE | ADMITTING ICD9-CM

PROVIDER STREET/MAILING ADDRESS

ADMITTING DIAGNOSIS DESCRIPTION

PROVIDER CITY, STATE AND ZIP CODE

FOR PHYSICIAN- PLEASE PROVIDE SUFFICIENT ESSENTIAL DETAIL TO PERMIT A REASONABLE EVALUATION OF THE LENGTH AND LEVEL OF CARE REQUESTED.

CURRENT DIAGNOSIS | CURRENT ICD9-CM CODE

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS

DESCRIBE CURRENT CONDITION REQUIRING EXTENSION. INCLUDE PERTINENT LAB AND X-RAY REPORTS WITH DATES.

WHAT PLANNED PROCEDURES WILL REQUIRE THIS EXTENSION. INCLUDE DATES WHEN POSSIBLE.

HOSPITAL: TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PROVIDER | DATE

TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN

SIGNATURE OF RESPONSIBLE PHYSICIAN | DATE

X

MEDI-CAL CONSULTANT- VALIDATING INFORMATION AND EXPLANATION

FOR STATE USE ONLY

DENIED

DEFERRED

APPROVED AS REQUESTED

APPROVED AS MODIFIED

24 FROM

24 THRU

DAYS

ACUTE | ACUTE ADMIN. | SUB ACUTE ADMIN. VENT. | SUB ACUTE ADMIN. IV/VENT

DAYS OF THIS HOSPITALIZATION ARE DENIED (SEE COMMENTS)

JACKSON VS RANK PARAGRAPH CODE

DATES OF DAYS DENIED

CHART REVIEWS

REVIEW COMMENTS INDICATOR

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (B)

MEDI-CAL CONSULTANT | ID. NO. | DATE

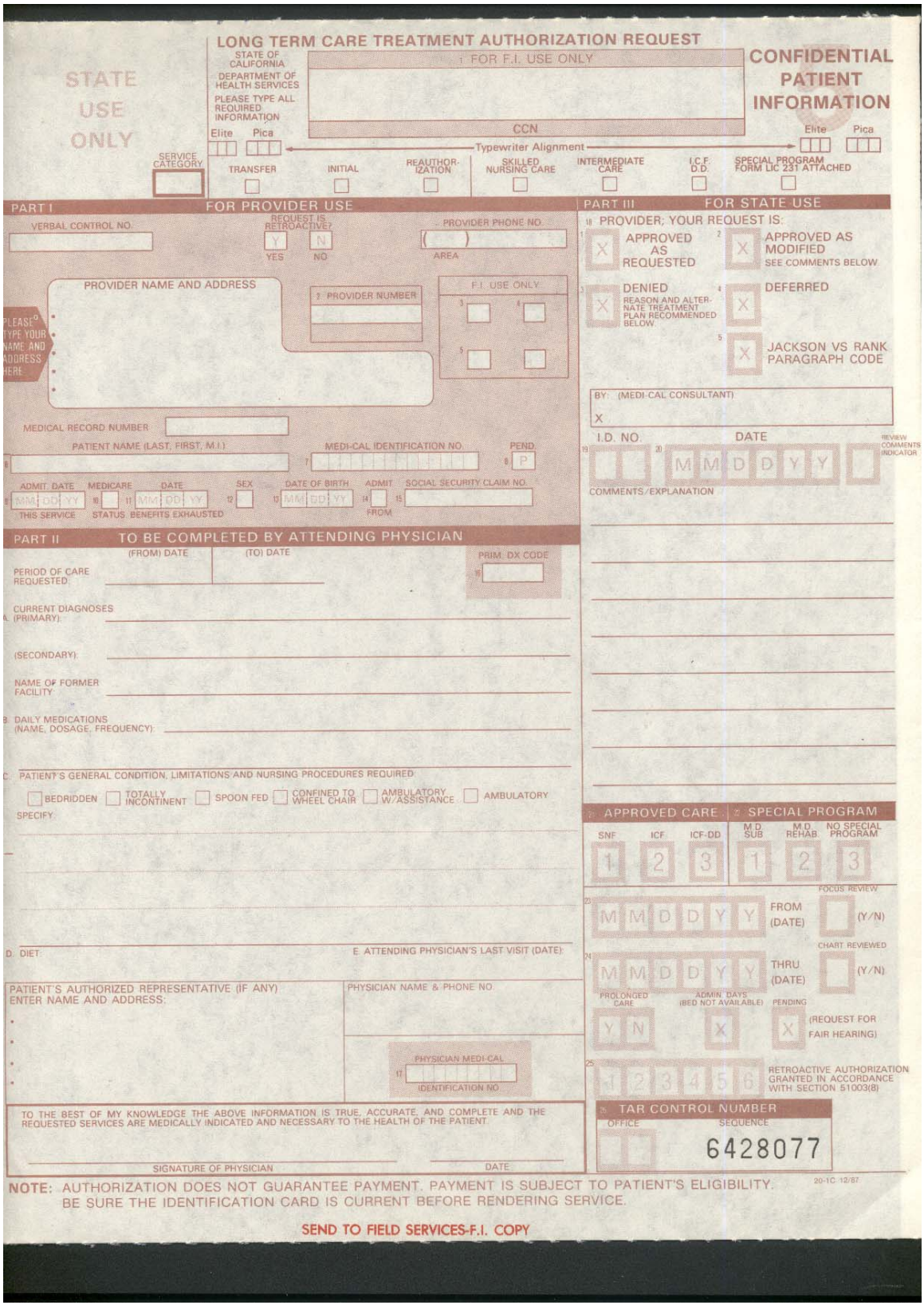
BY

TAR CONTROL NUMBER 28633401

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

18-1 8/93

SEND TO FIELD SERVICES - F.I. COPY



STATE USE ONLY

LONG TERM CARE TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
PLEASE TYPE ALL REQUIRED INFORMATION

1 FOR F.I. USE ONLY

CCN

CONFIDENTIAL PATIENT INFORMATION

Elite Pica — Typewriter Alignment — Elite Pica

SERVICE CATEGORY

TRANSFER | INITIAL | REAUTHORIZATION | SKILLED NURSING CARE | INTERMEDIATE CARE | I.C.F. D.D. | SPECIAL PROGRAM FORM LIC 231 ATTACHED

PART I FOR PROVIDER USE

VERBAL CONTROL NO.

REQUEST IS RETROACTIVE? Y YES N NO

PROVIDER PHONE NO. ( ) AREA

PROVIDER NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

2 PROVIDER NUMBER

F.I. USE ONLY 3 4 5

MEDICAL RECORD NUMBER

PATIENT NAME (LAST, FIRST, M.I.)

MEDI-CAL IDENTIFICATION NO. 7

PEND 8 P

ADMIT DATE THIS SERVICE 9 MM DD YY

MEDICARE STATUS 10 BENEFITS EXHAUSTED 11

DATE 11 MM DD YY

SEX 12

DATE OF BIRTH 13 MM DD YY

ADMIT FROM 14

SOCIAL SECURITY CLAIM NO. 15

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

PERIOD OF CARE REQUESTED (FROM) DATE (TO) DATE

PRIM. DX CODE 16

A. CURRENT DIAGNOSES (PRIMARY):

(SECONDARY):

NAME OF FORMER FACILITY:

B. DAILY MEDICATIONS (NAME, DOSAGE, FREQUENCY):

C. PATIENT'S GENERAL CONDITION, LIMITATIONS AND NURSING PROCEDURES REQUIRED:

☐ BEDRIDDEN ☐ TOTALLY INCONTINENT ☐ SPOON FED ☐ CONFINED TO WHEEL CHAIR ☐ AMBULATORY W/ASSISTANCE ☐ AMBULATORY

SPECIFY:

D. DIET:

E. ATTENDING PHYSICIAN'S LAST VISIT (DATE):

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

PHYSICIAN NAME & PHONE NO.

PHYSICIAN MEDI-CAL IDENTIFICATION NO. 17

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN DATE

PART III FOR STATE USE

18 PROVIDER; YOUR REQUEST IS:

1 X APPROVED AS REQUESTED

2 X APPROVED AS MODIFIED SEE COMMENTS BELOW.

3 X DENIED REASON AND ALTERNATE TREATMENT PLAN RECOMMENDED BELOW.

4 X DEFERRED

5 X JACKSON VS RANK PARAGRAPH CODE

BY: (MEDI-CAL CONSULTANT) X

I.D. NO. 19

DATE 20 M M D D Y Y

REVIEW COMMENTS INDICATOR

COMMENTS/EXPLANATION

21 APPROVED CARE: SNF 1 ICF 2 ICF-DD 3

22 SPECIAL PROGRAM: M.D. SUB 1 M.D. REHAB. 2 NO SPECIAL PROGRAM 3

23 FROM (DATE) M M D D Y Y

FOCUS REVIEW (Y/N)

24 THRU (DATE) M M D D Y Y

CHART REVIEWED (Y/N)

PROLONGED CARE Y N

ADMIN. DAYS (BED NOT AVAILABLE) X

PENDING X (REQUEST FOR FAIR HEARING)

25 1 2 3 4 5 6 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(8)

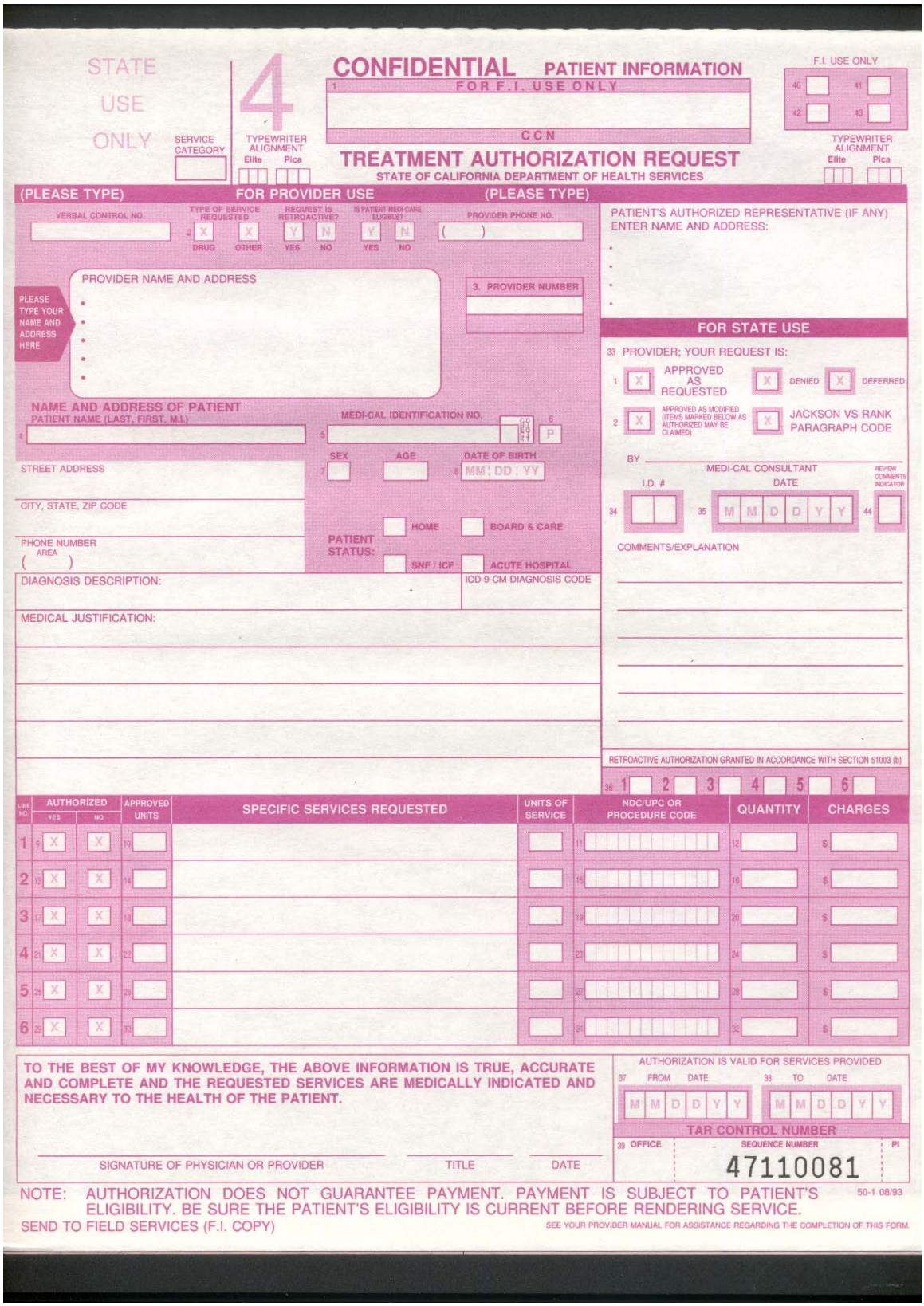
26 TAR CONTROL NUMBER

OFFICE SEQUENCE 6428077

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

20-1C 12/87

SEND TO FIELD SERVICES-F.I. COPY



STATE USE ONLY

SERVICE CATEGORY

4

TYPEWRITER ALIGNMENT Elite Pica

CONFIDENTIAL PATIENT INFORMATION

1 FOR F.I. USE ONLY

CCN

F.I. USE ONLY 40 41 42 43

TYPEWRITER ALIGNMENT Elite Pica

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)

VERBAL CONTROL NO.

2 TYPE OF SERVICE REQUESTED: X DRUG, X OTHER

REQUEST IS RETROACTIVE? Y YES, N NO

IS PATIENT MEDI-CARE ELIGIBLE? Y YES, N NO

PROVIDER PHONE NO. ( )

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS

3. PROVIDER NUMBER

NAME AND ADDRESS OF PATIENT

PATIENT NAME (LAST, FIRST, M.I.) 4

MEDI-CAL IDENTIFICATION NO. 5 CO SUF PER 6 P

SEX 7 AGE DATE OF BIRTH 8 MM DD YY

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER AREA ( )

PATIENT STATUS: HOME, BOARD & CARE, SNF / ICF, ACUTE HOSPITAL

DIAGNOSIS DESCRIPTION: ICD-9-CM DIAGNOSIS CODE

MEDICAL JUSTIFICATION:

FOR STATE USE

33 PROVIDER; YOUR REQUEST IS:

1 X APPROVED AS REQUESTED; X DENIED; X DEFERRED

2 X APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED); X JACKSON VS RANK PARAGRAPH CODE

BY

MEDI-CAL CONSULTANT I.D. # 34 DATE 35 M M D D Y Y REVIEW COMMENTS INDICATOR 44

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b) 36 1 2 3 4 5 6

LINE NO.	AUTHORIZED YES	AUTHORIZED NO	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPC OR PROCEDURE CODE	QUANTITY	CHARGES
1	9 X	X	10			11	12	$
2	13 X	X	14			15	16	$
3	17 X	X	18			19	20	$
4	21 X	X	22			23	24	$
5	25 X	X	26			27	28	$
6	29 X	X	30			31	32	$

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

37 FROM DATE M M D D Y Y 38 TO DATE M M D D Y Y

TAR CONTROL NUMBER

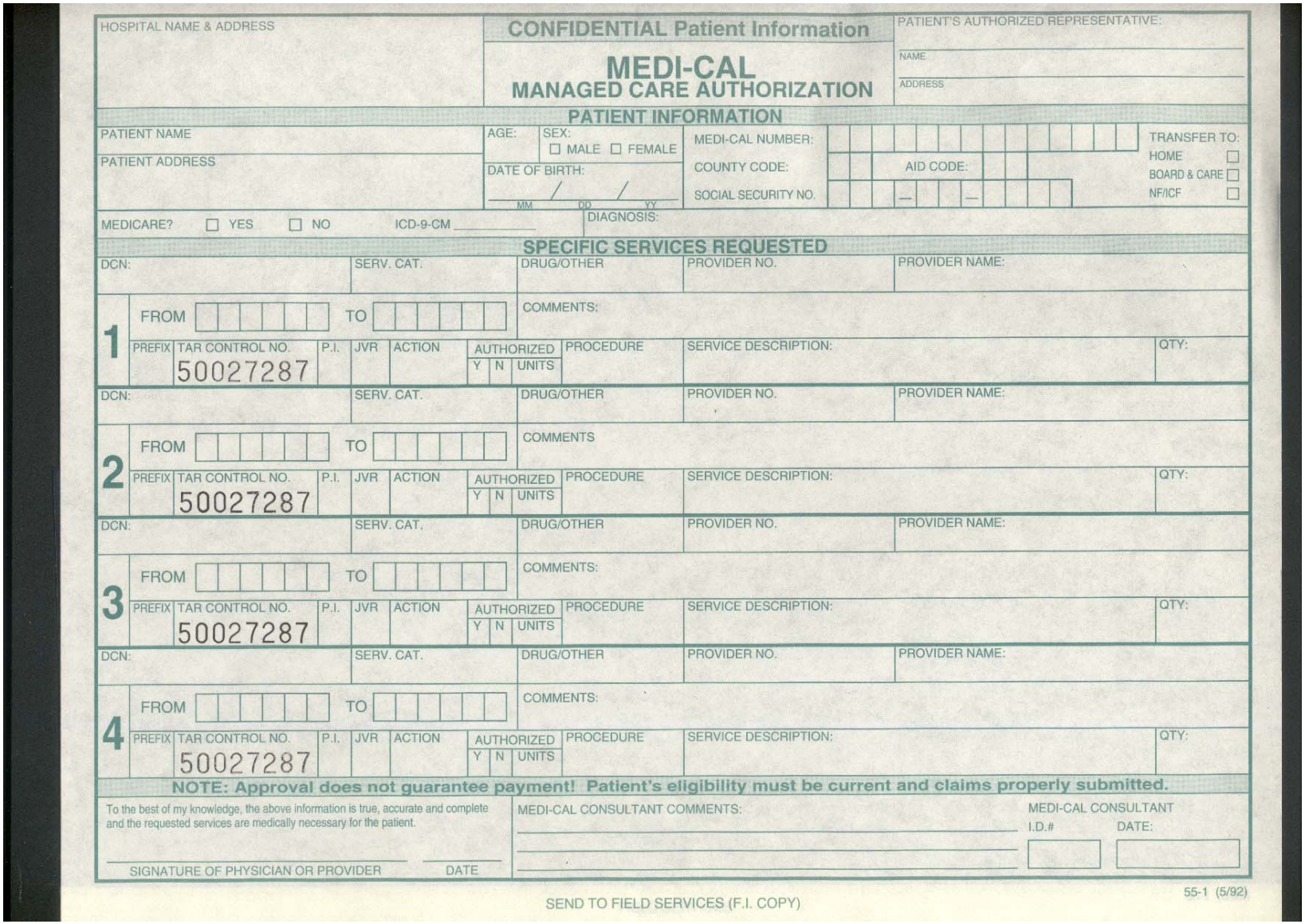
39 OFFICE SEQUENCE NUMBER 47110081 PI

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

50-1 08/93

SEND TO FIELD SERVICES (F.I. COPY)

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.



HOSPITAL NAME & ADDRESS

CONFIDENTIAL Patient Information

MEDI-CAL
MANAGED CARE AUTHORIZATION

PATIENT'S AUTHORIZED REPRESENTATIVE:
NAME
ADDRESS

PATIENT INFORMATION

PATIENT NAME
PATIENT ADDRESS
AGE: SEX: ☐ MALE ☐ FEMALE
DATE OF BIRTH: ___/___/___ (MM DD YY)
MEDI-CAL NUMBER:
COUNTY CODE: AID CODE:
SOCIAL SECURITY NO. ___-___-___
TRANSFER TO: HOME ☐ BOARD & CARE ☐ NF/ICF ☐
MEDICARE? ☐ YES ☐ NO ICD-9-CM ____ DIAGNOSIS:

SPECIFIC SERVICES REQUESTED

	DCN:	SERV. CAT.	DRUG/OTHER	PROVIDER NO.	PROVIDER NAME:
1					

FROM ____ TO ____ COMMENTS:

PREFIX	TAR CONTROL NO.	P.I.	JVR	ACTION	AUTHORIZED Y	AUTHORIZED N	AUTHORIZED UNITS	PROCEDURE	SERVICE DESCRIPTION:	QTY:
	50027287									

	DCN:	SERV. CAT.	DRUG/OTHER	PROVIDER NO.	PROVIDER NAME:
2					

FROM ____ TO ____ COMMENTS

PREFIX	TAR CONTROL NO.	P.I.	JVR	ACTION	AUTHORIZED Y	AUTHORIZED N	AUTHORIZED UNITS	PROCEDURE	SERVICE DESCRIPTION:	QTY:
	50027287									

	DCN:	SERV. CAT.	DRUG/OTHER	PROVIDER NO.	PROVIDER NAME:
3					

FROM ____ TO ____ COMMENTS:

PREFIX	TAR CONTROL NO.	P.I.	JVR	ACTION	AUTHORIZED Y	AUTHORIZED N	AUTHORIZED UNITS	PROCEDURE	SERVICE DESCRIPTION:	QTY:
	50027287									

	DCN:	SERV. CAT.	DRUG/OTHER	PROVIDER NO.	PROVIDER NAME:
4					

FROM ____ TO ____ COMMENTS:

PREFIX	TAR CONTROL NO.	P.I.	JVR	ACTION	AUTHORIZED Y	AUTHORIZED N	AUTHORIZED UNITS	PROCEDURE	SERVICE DESCRIPTION:	QTY:
	50027287									

NOTE: Approval does not guarantee payment! Patient's eligibility must be current and claims properly submitted.

To the best of my knowledge, the above information is true, accurate and complete and the requested services are medically necessary for the patient.

SIGNATURE OF PHYSICIAN OR PROVIDER ____ DATE ____

MEDI-CAL CONSULTANT COMMENTS:

MEDI-CAL CONSULTANT I.D.# ____ DATE: ____

SEND TO FIELD SERVICES (F.I. COPY)

55-1 (5/92)