TREATMENT AUTHORIZATION REQUEST (TAR)
COUNTY MEDICAL SERVICES PROGRAM (CMS)

Mark ☑ the appropriate boxes indicating which program will be utilized for the services requested.

☐ URGENT REQUEST ☐ RETRO TAR REQUEST

Please include all info required to substantiate medical necessity.

PATIENT INFORMATION	REFERRING PROVIDER INFORMATION Specialist ☐ Yes or ☐ No
Patient Name:_____	Name:_____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone Number: _____	Phone Number: _____
SSN: _____ **DOB:** _____	Clinic ID#: _____ Date: _____
Elig:_____**through** _____ (month) (year) (month) (year)	By: _____ (Print Physician's Name)

SPECIALIST INFORMATION	NOTICE TO PROVIDERS
Name:_____	Services beyond those authorized in this referral must be specifically authorized by CMS. The referral is valid only when patient is certified. You may verify certificaton when the patient presents his/her identification card . The service must be provided prior to the expiration date noted below. Unauthorized services or services not specifically noted will not be honored for payment.
Address: _____	
City/State/Zip: _____	
Phone Number: _____**Appt. Date:** _____	

SERVICES REQUESTED WITH THIS REFERRAL:_____

_____

CPT Codes: _____ICD-9 Codes_____

CLINICAL INFORMATION, including pertinent lab, x-ray and treatment to date: _____

_____

_____ Clinic MD Signature:_____

Data Enclosed: Lab Reports [ ] X-ray [ ] Narrative Reports [ ] Med. Reports [ ] Other:_____

WRITTEN FINDINGS THAT ARE A RESULT OF THE REFERRAL SHOULD BE PROMPTLY SENT TO THE PRIMARY CARE PROVIDER

TAR NUMBER:_____ BY:_____ EXP. DATE: _____

SERVICES AUTHORIZED: _____

THIS AREA FOR SPECIALIST RESPONSE**:** _____

_____

DATE:_____Specialist Signature:_____

FOR FURTHER INFORMATION CONTACT CMS Authorization Department at (858) 658-8650
Mail or Fax TAR to: CMS Authorizations PO Box 927110, San Diego, CA 92192
Fax TAR to: (855) 394-7927