San Bernardino County Department of Behavioral Health

Fee-For-Service Provider- Outpatient Treatment Authorization Request (TAR)

All items must be addressed. Approval is based on documentation of Medical Necessity (Functional Impairments)

PART 1	BENEFICIARY INFORMATION		
Client Name		DOB	
Phone		SSN or Medi-Cal Number	
Address		City & Zip Code	
Living Arrangement	☐ Independent ☐ Bio Family ☐ Foster Family ☐ Group Home ☐ SNF ☐ B&C		
Minor is under the jurisdiction of:	☐ DCS ☐ Court ☐ Probation ☐ Bio Family ☐ Other		

PART 2	PROVIDER INFORMATION				
Provider Name					
Provider Service Site Address			City & Zip Code		
Phone #	( )	Fax #	( )	Licensure	☐Psychiatrist ☐Psychologist ☐ LCSW ☐ LMFT

PART 3	TREATMENT AUTHORIZATION REQUESTED *(check all that apply)*		
☐ Adult ☐Minor CFS Active ☐ Yes ☐ No	☐Initial Authorization Assessment Date __/__/____ *(for claims)*	☐Re-Authorization ☐Changes to Authorization	**Received Date Stamp** *(County Use Only):*
Coordination of Care with		☐PCP ☐Psychiatrist ☐Psychologist ☐ LCSW ☐ LMFT ☐ DCFS ☐Other________________________	
Modality & Requested Units *(For Psychologist, LCSW, LMFT)*		☐ Individual ___ ☐Family__ ☐Case Conference___ ☐Group___ ***Authorizations are for 6 months cycles.***	
Modality & Requested Units *(For Psychiatrist)*		☐ Pharmacological Management *___ ***Authorizations for minors are for 6 months cycles. Authorizations for adults are for 12 months.***	***NOTE: Signed Medication Consent Form MUST be attached for Initial Requests.**

PART 4	MEDICAL NECESSITY
Current Presenting Problem: (*Clinical Symptoms and Behaviors)*	

Mental Status		
	Appearance	☐Clean ☐ Groomed ☐Dirty ☐Disheveled
	Speech	☐Organized ☐Coherent ☐Pressured ☐Rapid ☐Slow ☐Mumbling
	Orientation	☐Person ☐Place ☐Time ☐Situation
	Affect	☐Appropriate ☐Blunted/Flat ☐Restricted ☐Labile ☐Tearful
	Insight	☐Good ☐Average ☐Poor ☐None
	Judgment	☐Good ☐Average ☐Poor ☐None
	Mood	☐Stable ☐Depressed ☐Irritable ☐Anxious ☐Manic ☐Elevated
	Perception	☐Normal ☐Auditory Hallucinations ☐Visual Hallucinations ☐Other__________
	Thought Content	☐Normal ☐Delusional ☐Grandiose ☐Paranoid ☐Phobic ☐Other__________
	Thought Process	☐Organized ☐Poor Concentration ☐Obsessive ☐Flight of Ideas ☐ Thought Blocking

Risk Assessments		
	Suicidal Ideation	☐None ☐Ideation ☐Intent ☐Plan ☐Means ☐History Describe:________________________
	Homicidal Ideation	☐None ☐Ideation ☐Intent ☐Plan ☐Means ☐History Describe:________________________

Prior Inpatient Psychiatric Admissions	☐**None** ☐**Yes (# last year)____**	Other Outpatient Mental Health Services	☐**None** ☐ **Yes ____________________**

Medical Conditions	Health Problems	☐ None ☐ Yes / Describe:		
	Sleep Problems	☐ None ☐ Yes / Describe:		
	Appetite Changes	☐ None ☐ Yes / Describe:		
	Adverse Response to Medication	☐ None ☐ Yes / Describe:		
	Height / Weight *(required for minors)*	Height Changes		Weight (lbs) Changes

Current Medication	Name	Dose	Frequency	Target Symptoms
Past Medications				

CURRENT DIAGNOSIS

Axis	Code	Name *(please make sure name matches with the code reported)*
I		
II		
III		
IV	☐ *Primary Support* ☐ *Social Environment* ☐ *Educational* ☐ *Occupational* ☐ *Housing* ☐ *Economic* ☐ *Legal* ☐ *Access to Health Care Services* ☐ Other/Specify________________	
V	GAF Score	

Impairment Criteria *(minimum one due to the documented Axis I diagnosis)*	☐ A significant impairment in an important area of life functioning. ☐ A probability of significant deterioration in an important area of life functioning. ☐ A probability that the client will not progress developmentally as individually appropriate. ☐ For EPSDT beneficiaries, a condition due to a mental disorder that specialty mental health services can improve.
Intervention Criteria *(must have 1,2, and 3 or 3 and 4)*	☐ **1.** The focus of treatment is to address the condition identified in the impairment criteria. ☐ **2.** The proposed intervention will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning or allow the client to progress developmentally as individually appropriate. ☐ **3.** The condition would not be responsive to physical health care based treatment. ☐ **4.** For EPSDT beneficiaries, a condition due to a mental disorder that specialty mental health services can improve.

PART 5	PROVIDER NAME & SIGNATURE (I certify that the above information is accurate and all the eligibility documentation required are on file)			
Provider Name		Provider Signature		Date

FAX COMPLETED FORM TO COUNTY OF SAN BERNARDINO ACCESS UNIT AT (909) 421-9272.
Authorization requests are processed within 14 calendar days from date this completed TAR is received by the unit.

PART 6	MHP ACTION: (COUNTY USE ONLY)			
☐ **Unable to Process**	☐ Missing required information ☐ Unable to locate beneficiary ☐ Duplication of services ☐ Other:			
Action	☐ Approved (*Authorization letter sent*) ☐ 14 Calendar Days Extension Request Made Extension to:__/__/___ *=28 days from original stamp date*	☐ Modified ☐ Denied	☐ NOA-B Issued __/__/____	☐**Provider Notified**__/__/____ ☐**Beneficiary Notified**__/__/____
Reason for 14 Days Extension or Comments				
Access Unit Reviewer Name		Signature		
Reviewer Title / License		Date		