

Community Supports Treatment Authorization Requests

This document serves as a Treatment Authorization Request (TAR) reference guide for Community Supports (CS) providers. Please use the guide below to submit correct TARs. **Incorrect TARs will be voided.**

Online Services Provider Portal Link: <https://provider.partnershiphp.org/UI/Login.aspx>

Questions: Please email CommunitySupports@partnershiphp.org

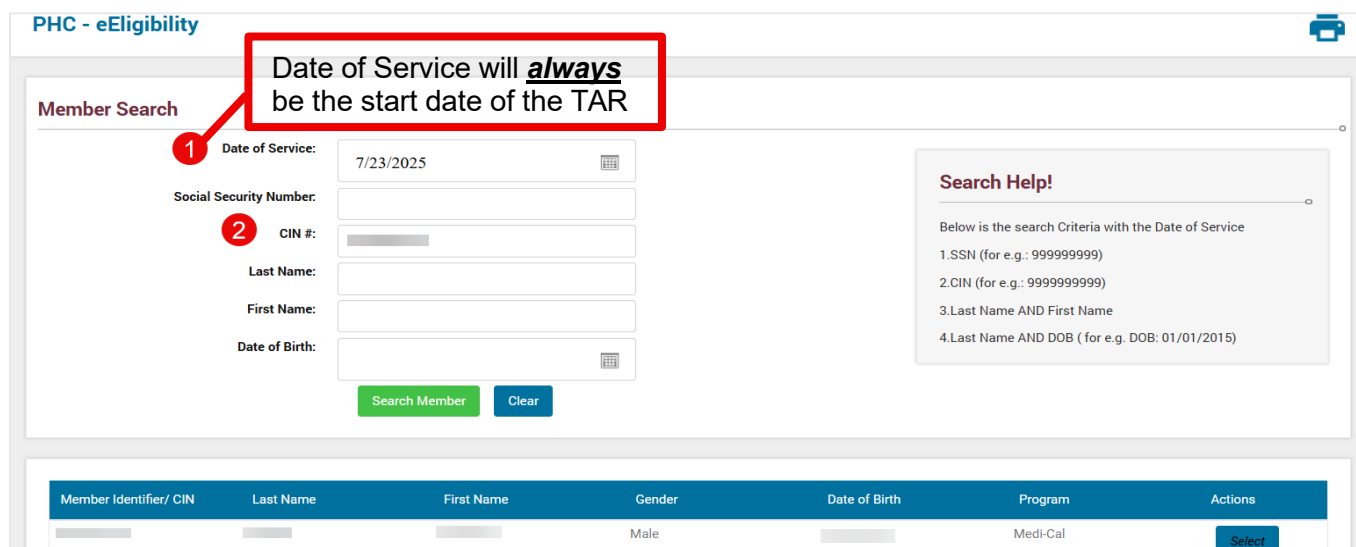
TAR Date Spans:

- ✓ Housing Transition Navigation and Housing Tenancy – Up to maximum of six months
- ✓ Personal Care and Homemaker Services – Three months
- ✓ Housing Deposits and Asthma Remediation – Two months
- ✓ Respite Services – One year/12-months
- ✓ Sobering Centers – One day/23:59 hours
- ✓ Day Habilitation Programs – 180 days
- ✓ Medically Tailored Meals/Groceries – Six months
- ✓ Recuperative Care/Short-Term Post-Hospitalization Housing - **Subject to Global Cap process**

Important Reminder:

- *If a member has a Housing Transition Navigation (HTNS) TAR it must have an end date of the month prior to the Housing Tenancy and Sustaining Services (HTSS) TAR*
- **Please remember that a member's HTNS TAR should have the end date added once a Housing Deposit is paid. At this point, a member may be enrolled in HTSS, and HTNS would no longer be appropriate.**

HTNS: Up to maximum of six months – End date should be up to maximum of six months from the start date.



PHC - eEligibility

Member Search

1 Date of Service: 7/23/2025

2 Social Security Number:

CIN #:

Last Name:

First Name:

Date of Birth:

Search Member Clear

Date of Service will always be the start date of the TAR

Search Help!

Below is the search Criteria with the Date of Service

- 1.SSN (for e.g.: 999999999)
- 2.CIN (for e.g.: 999999999)
- 3.Last Name AND First Name
- 4.Last Name AND DOB (for e.g. DOB: 01/01/2015)

Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	Select



Community Supports Treatment Authorization Requests

Click on Select, providers will review eligibility for services. Community Supports TARs will always be Outpatient eTARs.

You will see this landing page below once clicked on Submit Outpatient eTAR

TAR Start & End Dates

START DATE: 7/23/2025 END DATE: * 1/23/2026

TAR TYPE: *
Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.
Community Supports

SELECT PROVIDER: *
[Redacted]

SERVICE PROVIDER ADDRESS:
[Redacted]

PREFERRED RETURN FAX#:
[Redacted]

IS URGENT:
No

SERVICE PROVIDER DETAILS:
[Redacted]

PROVIDER FAX# (ON FILE):
[Redacted]

PATIENT CURRENT LOCATION: *
Homeless

Service Details should be entered and appear exactly as below:

Diagnosis Details & Medical Justification

PRIMARY DIAGNOSIS: * (No decimal point needed)
Z5900

DIAGNOSIS CODE:
Z5900

DIAGNOSIS DESCRIPTION:
Homelessness unspecified

SECONDARY DIAGNOSIS: (No decimal point needed)
Search diagnosis based on diagnosis code or its description

SECONDARY CODE:
[Redacted]

SECONDARY DESCRIPTION:
[Redacted]

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
H0043	SUPPORTED HOUSING, PER DIEM	U6			0	6	0	Edit Delete
Add New Service Code								

A Community Supports (CS) TAR **must always** have a CS Referral Form attached via provider portal

Attachments:

Attachments: 0

Attach supporting documentation here.

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.


Note: Clicking Submit TAR is equivalent to signature.

[Submit eTAR](#)




Housing Deposits: Two months – End date should be two months from the start date.

Submit the following:

PHC - eEligibility 

Date of Service will ***always*** be the start date of the TAR

Member Search


1 Date of Service: 

Social Security Number:

2 CIN #:

Last Name:

First Name:

Date of Birth: 

Search Help!

Below is the search Criteria with the Date of Service


- 1.SSN (for e.g.: 999999999)
- 2.CIN (for e.g.: 9999999999)
- 3.Last Name AND First Name
- 4.Last Name AND DOB (for e.g. DOB: 01/01/2015)

Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	<input type="button" value="Select"/>

Click on Select, providers will review eligibility for services. Community Supports TARs will always be Outpatient eTARs. You will see this landing page below once clicked on Submit Outpatient eTAR:

TAR Start & End Dates

START DATE: END DATE: *

TAR TYPE: *  Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.

SELECT PROVIDER: *

SERVICE PROVIDER ADDRESS:

PREFERRED RETURN FAX#:

IS URGENT:

SERVICE PROVIDER DETAILS:

PROVIDER FAX# (ON FILE):

PATIENT CURRENT LOCATION: *

Community Supports Treatment Authorization Requests

Service Details should be entered and appear exactly as below:

Diagnosis Details & Medical Justification

PRIMARY DIAGNOSIS: * (No decimal point needed) <input style="width: 95%;" type="text" value="Z5900"/>	DIAGNOSIS CODE: <input style="width: 95%;" type="text" value="Z5900"/>	DIAGNOSIS DESCRIPTION: <input style="width: 95%;" type="text" value="Homelessness unspecified"/>
SECONDARY DIAGNOSIS: (No decimal point needed) <input style="width: 95%;" type="text" value="Search diagnosis based on diagnosis code or its description"/>	SECONDARY CODE: <input style="width: 95%;" type="text"/>	SECONDARY DESCRIPTION: <input style="width: 95%;" type="text"/>

MEDICAL JUSTIFICATION: (MAX CHARACTER LIMIT IS 1500 CHARACTERS)

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
H0044	SUPPORTED HOUSING, PER MONTH	U2			0	1	0	Edit Delete

Add New Service Code

A Community Supports (CS) TAR **must always** have a CS Referral Form* attached via provider portal and providers are expected to attach:

- HD Request Form* ***Provider Signature Required***
- Housing Support Plan*
- Household item receipts and/or purchase orders, documentation, screenshots, and/or items requested
- Copy of lease or similar document

Required forms can be found on our CalAIM Webpage.

Attachments:

Attachments: 0

Attach supporting documentation here.

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.

Submit eTAR

Community Supports Treatment Authorization Requests

HTSS: Up to maximum of six months – End date should be up to maximum of six months from the start date.

Submit the following:

PHC - eEligibility

Member Search

Date of Service will ***always*** be the start date of the TAR

1 Date of Service:

Social Security Number:

2 CIN #:

Last Name:

First Name:

Date of Birth:

Search Help!

Below is the search Criteria with the Date of Service

- 1.SSN (for e.g.: 999999999)
- 2.CIN (for e.g.: 999999999)
- 3.Last Name AND First Name
- 4.Last Name AND DOB (for e.g. DOB: 01/01/2015)

Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	<input type="button" value="Select"/>

Click on Select, providers will review eligibility for services. Community Supports TARs will always be Outpatient eTARs. You will see this landing page below once clicked on Submit Outpatient eTAR:

TAR Start & End Dates

START DATE: **END DATE: ***

TAR TYPE: *

Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.

SERVICE PROVIDER DETAILS:

PROVIDER FAX# (ON FILE):

PATIENT CURRENT LOCATION: *

SELECT PROVIDER: *

SERVICE PROVIDER ADDRESS:

PREFERRED RETURN FAX#:

IS URGENT:

Community Supports Treatment Authorization Requests

Diagnosis Details should be entered and appear exactly as below and **submit ONE of the three service details options:**

Diagnosis Details & Medical Justification

PRIMARY DIAGNOSIS: * (No decimal point needed)

Z59812

DIAGNOSIS CODE:

Z59812

DIAGNOSIS DESCRIPTION:

Housing instability, housed, homelessness in past 12 months

SECONDARY DIAGNOSIS: (No decimal point needed)

Search diagnosis based on diagnosis code or its description

SECONDARY CODE:

SECONDARY DESCRIPTION:

1. Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
T2041	SUPPORT BROKER WAIVER/ 15 MIN	U6			0	6	0	Edit Delete
T2040	FINANCIAL MGT WAIVER/ SERVICE	U6			0	6	0	Edit Delete

Add New Service Code

2. Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
T2040	FINANCIAL MGT WAIVER/ SERVICE	U6			0	12	0	Edit Delete

Add New Service Code

3. Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
T2041	SUPPORT BROKER WAIVER/ 15 MIN	U6			0	12	0	Edit Delete

Add New Service Code

A Community Supports (CS) TAR **must always** have a CS Referral Form attached via provider portal:

Attachments:

Attachments: 0

Attach supporting documentation here.

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.

Submit eTAR

Personal Care/Homemaker: Three months – End Date should be three months from the start date.

Submit the following:

PHC - eEligibility

Date of Service will ***always*** be the start date of the TAR

Member Search

1 Date of Service:

Social Security Number:

2 CIN #:

Last Name:

First Name:

Date of Birth:

Search Help!

Below is the search Criteria with the Date of Service

- 1.SSN (for e.g.: 999999999)
- 2.CIN (for e.g.: 999999999)
- 3.Last Name AND First Name
- 4.Last Name AND DOB (for e.g. DOB: 01/01/2015)

Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	<input type="button" value="Select"/>

Click on Select, providers will review eligibility for services. Community Supports TARs will always be Outpatient eTARs. You will see this landing page below once clicked on Submit Outpatient eTAR:

TAR Start & End Dates

START DATE: **END DATE: ***

TAR TYPE: *
Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.

SELECT PROVIDER: *

SERVICE PROVIDER DETAILS:

SERVICE PROVIDER ADDRESS:

PROVIDER FAX# (ON FILE):

PREFERRED RETURN FAX#:

PATIENT CURRENT LOCATION: *

IS URGENT:

Service Details should be entered and appear exactly as below:

Diagnosis Details & Medical Justification

PRIMARY DIAGNOSIS: * (No decimal point needed)

DIAGNOSIS CODE:

DIAGNOSIS DESCRIPTION:

SECONDARY DIAGNOSIS: (No decimal point needed)

SECONDARY CODE:

SECONDARY DESCRIPTION:

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges		
S5130	HM SVS, NOS, 15 MIN	U6			0	960	0		

[Add New Service Code](#)

A Community Supports (CS) TAR **must always** have a CS Referral Form attached via provider portal:

Attachments:

Attachments: 0

[Attach supporting documentation here.](#)

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.

[Submit eTAR](#)

Community Supports Treatment Authorization Requests

Respite Services: 1 year/12-month – End date should be 1 year/12-month from the start date.

Submit the following:

PHC - eEligibility

Date of Service will always be the start date of the TAR

Member Search

1 **Date of Service:**

Social Security Number:

2 **CIN #:**

Last Name:

First Name:

Date of Birth:

Search Help!

Below is the search Criteria with the Date of Service

- 1.SSN (for e.g.: 999999999)
- 2.CIN (for e.g.: 999999999)
- 3.Last Name AND First Name
- 4.Last Name AND DOB (for e.g. DOB: 01/01/2015)

Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	<input type="button" value="Select"/>

Click on Select, providers will review eligibility for services. Community Supports TARs will always be Outpatient eTARs. You will see this landing page below once clicked on Submit Outpatient eTAR:

TAR Start & End Dates

START DATE:

END DATE: *

TAR TYPE: *

Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.

Community Supports

SELECT PROVIDER: *

SERVICE PROVIDER ADDRESS:

PREFERRED RETURN FAX#:

IS URGENT:

No

SERVICE PROVIDER DETAILS:

PROVIDER FAX# (ON FILE):

PATIENT CURRENT LOCATION: *

Homeless

Community Supports Treatment Authorization Requests

Service Details should be entered and appear exactly as below:

Diagnosis Details & Medical Justification

PRIMARY DIAGNOSIS: * (No decimal point needed) <input style="width: 95%;" type="text" value="Z600"/>	DIAGNOSIS CODE: <input style="width: 95%;" type="text" value="Z600"/>	DIAGNOSIS DESCRIPTION: <input style="width: 95%;" type="text" value="Problems of adjustment to life-cycle transitions"/>
SECONDARY DIAGNOSIS: (No decimal point needed) <input style="width: 95%;" type="text" value="Search diagnosis based on diagnosis code or its description"/>	SECONDARY CODE: <input style="width: 95%;" type="text"/>	SECONDARY DESCRIPTION: <input style="width: 95%;" type="text"/>

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
S9125	RESPITE CARE, IN THE HOME, P	U6			0	1344	0	Edit Delete

[Add New Service Code](#)

Attachments:

Attachments: 0

Attach supporting documentation here.

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.

[Submit eTAR](#)

A Community Supports (CS) TAR **must always** have a CS Referral Form attached via provider portal:

Recuperative Care: Six months – End date should be six months from the start date. Duration will be subject to Global Cap process.

Submit the following:

PHC - eEligibility

Member Search

1 Date of Service:

Social Security Number:

2 CIN #:

Last Name:

First Name:

Date of Birth:

Search Help!

Below is the search Criteria with the Date of Service

- 1.SSN (for e.g.: 999999999)
- 2.CIN (for e.g.: 999999999)
- 3.Last Name AND First Name
- 4.Last Name AND DOB (for e.g. DOB: 01/01/2015)

Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	<input type="button" value="Select"/>

Click on Select, providers will review eligibility for services. Community Supports TARs will always be Outpatient eTARs. You will see this landing page below once clicked on Submit Outpatient eTAR:

TAR Start & End Dates

START DATE: **END DATE: ***

TAR TYPE: *

SELECT PROVIDER: *

SERVICE PROVIDER DETAILS:

SERVICE PROVIDER ADDRESS:

PROVIDER FAX# (ON FILE):

PREFERRED RETURN FAX#:

PATIENT CURRENT LOCATION: *

IS URGENT:

Community Supports Treatment Authorization Requests

Service Details should be entered and appear exactly as below:

Diagnosis Details & Medical Justification

PRIMARY DIAGNOSIS: * (No decimal point needed) <input style="width: 90%;" type="text" value="Z5900"/>	DIAGNOSIS CODE: <input style="width: 90%;" type="text" value="Z5900"/>	DIAGNOSIS DESCRIPTION: <input style="width: 90%;" type="text" value="Homelessness unspecified"/>
SECONDARY DIAGNOSIS: (No decimal point needed) <input style="width: 90%;" type="text" value="Search diagnosis based on diagnosis code or its description"/>	SECONDARY CODE: <input style="width: 90%;" type="text"/>	SECONDARY DESCRIPTION: <input style="width: 90%;" type="text"/>

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
T2033	RES NOS WAIVER PER DIEM	U6			0	1	0	Edit Delete

[Add New Service Code](#)

ADDITIONAL NOTES: (MAX CHARACTER LIMIT IS 700 CHARACTERS)

Member will be residing at: 123 Mickey Mouse Ave Fairfield, CA 98888 for Recuperative Care (RC).

A Community Supports (CS) TAR **must always** have a CS Referral Form attached via provider portal and providers are required to submit address of where member is residing for room and board services, please see screenshot above:

Attachments:

Attachments: 0

Attach supporting documentation here.

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.

[Submit eTAR](#)

Short-Term Post-Hospitalization: Six months – End date should be six months from the start date. Duration will be subject to Global Cap process.

Submit the following:

PHC - eEligibility

Member Search

1 Date of Service:

Social Security Number:

2 CIN #:

Last Name:

First Name:

Date of Birth:

Search Help!

Below is the search Criteria with the Date of Service

- 1.SSN (for e.g.: 999999999)
- 2.CIN (for e.g.: 999999999)
- 3.Last Name AND First Name
- 4.Last Name AND DOB (for e.g. DOB: 01/01/2015)

Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	<input type="button" value="Select"/>

Click on Select, providers will review eligibility for services. Community Supports TARs will always be Outpatient eTARs. You will see this landing page below once clicked on Submit Outpatient eTAR:

TAR Start & End Dates

START DATE: **END DATE: ***

TAR TYPE: *
Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.

SELECT PROVIDER: *

SERVICE PROVIDER DETAILS:

SERVICE PROVIDER ADDRESS:

PROVIDER FAX# (ON FILE):

PREFERRED RETURN FAX#:

PATIENT CURRENT LOCATION: *

IS URGENT:

Community Supports Treatment Authorization Requests

Service Details should be entered and appear exactly as below:

Diagnosis Details & Medical Justification

PRIMARY DIAGNOSIS: * (No decimal point needed) <input style="width: 95%;" type="text" value="Z5900"/>	DIAGNOSIS CODE: <input style="width: 95%;" type="text" value="Z5900"/>	DIAGNOSIS DESCRIPTION: <input style="width: 95%;" type="text" value="Homelessness unspecified"/>
SECONDARY DIAGNOSIS: (No decimal point needed) <input style="width: 95%;" type="text" value="Search diagnosis based on diagnosis code or its description"/>	SECONDARY CODE: <input style="width: 95%;" type="text"/>	SECONDARY DESCRIPTION: <input style="width: 95%;" type="text"/>

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
H0044	SUPPORTED HOUSING, PER MONTH	U3			0	1	0	Edit Delete

[Add New Service Code](#)

ADDITIONAL NOTES: (MAX CHARACTER LIMIT IS 700 CHARACTERS)

Member will be residing at: 123 Mickey Mouse Ave Fairfield, CA 98888 for Short Term Post Hospitalization Housing (STPHH).

A Community Supports (CS) TAR **must always** have a CS Referral Form attached via provider portal and providers are required to submit address of where member is residing for room and board services, please see screenshot above:

Attachments:

Attachments: 0

Attach supporting documentation here.

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.

[Submit eTAR](#)

Community Supports Treatment Authorization Requests

Day Habilitation Programs: 180 days– End date should be exactly 180 days from the start date.

Submit the following:

PHC - eEligibility

Date of Service will ***always*** be the start date of the TAR

Member Search

1 Date of Service:

Social Security Number:

2 CIN #:

Last Name:

First Name:

Date of Birth:

Search Member Clear

Search Help!

Below is the search Criteria with the Date of Service

- 1.SSN (for e.g.: 999999999)
- 2.CIN (for e.g.: 999999999)
- 3.Last Name AND First Name
- 4.Last Name AND DOB (for e.g. DOB: 01/01/2015)

Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	Select

Click on Select, providers will review eligibility for services. Community Supports TARs will always be Outpatient eTARs. You will see this landing page below once clicked on Submit Outpatient eTAR:

TAR Start & End Dates

START DATE:

END DATE: *

SELECT PROVIDER: *

SERVICE PROVIDER ADDRESS:

PREFERRED RETURN FAX#:

IS URGENT:

TAR TYPE: *

Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.

SERVICE PROVIDER DETAILS:

PROVIDER FAX# (ON FILE):

PATIENT CURRENT LOCATION: *

Community Supports Treatment Authorization Requests

Service Details should be entered and appear exactly as below:

Diagnosis Details & Medical Justification

PRIMARY DIAGNOSIS: * (No decimal point needed) Z5900	DIAGNOSIS CODE: Z5900	DIAGNOSIS DESCRIPTION: Homelessness unspecified
SECONDARY DIAGNOSIS: (No decimal point needed) Search diagnosis based on diagnosis code or its description	SECONDARY CODE:	SECONDARY DESCRIPTION:

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
T2020	DAY HABIL WAIVER PER DIEM	U6			0	1440	0	Edit Delete

[Add New Service Code](#)

A Community Supports (CS) TAR **must always** have a CS Referral Form attached via provider portal:

Attachments:

Attachments: 0

[Attach supporting documentation here.](#)

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.

[Submit eTAR](#)

Medically Tailored Meals/Groceries: Six months – End date will be six months from the start date for delivery delays. This service will be approved for 12 weeks only.

Submit the following:

PHC - eEligibility

Date of Service will ***always*** be the start date of the TAR

Member Search

1 Date of Service:

Social Security Number:

2 CIN #:

Last Name:

First Name:

Date of Birth:

Search Help!

Below is the search Criteria with the Date of Service

1. SSN (for e.g.: 999999999)
2. CIN (for e.g.: 999999999)
3. Last Name AND First Name
4. Last Name AND DOB (for e.g. DOB: 01/01/2015)

Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
██████████	██████████	██████████	Male	██████████	Medi-Cal	<input type="button" value="Select"/>

Click on Select, providers will review eligibility for services. Community Supports TARs will always be Outpatient eTARs. You will see this landing page below once clicked on Submit Outpatient eTAR:

TAR Start & End Dates

START DATE:

END DATE: *

TAR TYPE: *

Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.

SERVICE PROVIDER DETAILS:

PROVIDER FAX# (ON FILE):

PATIENT CURRENT LOCATION: *

SELECT PROVIDER: *

SERVICE PROVIDER ADDRESS:

PREFERRED RETURN FAX#:

IS URGENT:



Community Supports Treatment Authorization Requests

Service Details should be entered and appear exactly as below for **Medically Tailored Meals**:

Diagnosis Details & Medical Justification

PRIMARY DIAGNOSIS: * (No decimal point needed)

Z5948

DIAGNOSIS CODE:

Z5948

DIAGNOSIS DESCRIPTION:

Other specified lack of adequate food

SECONDARY DIAGNOSIS: (No decimal point needed)

Search diagnosis based on diagnosis code or its description

SECONDARY CODE:

SECONDARY DESCRIPTION:

MEDICAL JUSTIFICATION: (MAX CHARACTER LIMIT IS 1500 CHARACTERS)

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
S5170	HOME DEL, INCL PREP, PER MEL	U6			0	168	0	Edit Delete
S9470	NUTRITIONAL COUNSELING, DIET	U6			0	4	0	Edit Delete

[Add New Service Code](#)

A Community Supports (CS) TAR **must always** have a CS Referral Form attached via provider portal:

- Initial TARs – Assessment, unless otherwise specified (i.e., hospital discharge with specific conditions)
- Reauth TARs - MTM Reauth Form

Attachments:

Attachments: 0

[Attach supporting documentation here.](#)

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.

[Submit eTAR](#)



Community Supports Treatment Authorization Requests

OR Service Details should be entered and appear exactly as below for **Medically Tailored Groceries**:

Diagnosis Details & Medical Justification

PRIMARY DIAGNOSIS: * (No decimal point needed)

Z5948

DIAGNOSIS CODE:

Z5948

DIAGNOSIS DESCRIPTION:

Other specified lack of adequate food

SECONDARY DIAGNOSIS: (No decimal point needed)

Search diagnosis based on diagnosis code or its description

SECONDARY CODE:

SECONDARY DESCRIPTION:

MEDICAL JUSTIFICATION: (MAX CHARACTER LIMIT IS 1500 CHARACTERS)

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
S9977	MEALS PER DIEM	U6			0	12	0	Edit Delete
S9470	NUTRITIONAL COUNSELING, DIET	U6			0	4	0	Edit Delete

[Add New Service Code](#)

A Community Supports (CS) TAR **must always** have a CS Referral Form attached via provider portal:

- Initial TARs – Assessment, unless otherwise specified (i.e., hospital discharge with specific conditions)
- Reauth TARs - MTM Reauth Form

Attachments:

Attachments: 0

Attach supporting documentation here.

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.

[Submit eTAR](#)



Sobering Centers: 1 day, 23:59 hours – End date will be the same as the start date

Submit the following:

PHC - eEligibility

Member Search

Date of Service will ***always*** be the start date of the TAR

1 Date of Service:

Social Security Number:

2 CIN #:

Last Name:

First Name:

Date of Birth:

Search Help!

Below is the search Criteria with the Date of Service

- 1.SSN (for e.g.: 999999999)
- 2.CIN (for e.g.: 999999999)
- 3.Last Name AND First Name
- 4.Last Name AND DOB (for e.g. DOB: 01/01/2015)

Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	<input type="button" value="Select"/>

Click on Select, providers will review eligibility for services. Community Supports TARs will always be Outpatient eTARs. You will see this landing page below once clicked on Submit Outpatient eTAR:

TAR Start & End Dates

START DATE: **END DATE: ***

TAR TYPE: *

Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.

SELECT PROVIDER: *

SERVICE PROVIDER ADDRESS:

PREFERRED RETURN FAX#:

IS URGENT:

SERVICE PROVIDER DETAILS:

PROVIDER FAX# (ON FILE):

PATIENT CURRENT LOCATION: *

Community Supports Treatment Authorization Requests

Service Details should be entered and appear exactly as below:

Diagnosis Details & Medical Justification

PRIMARY DIAGNOSIS: * (No decimal point needed) <input style="width: 90%;" type="text" value="Z5900"/>	DIAGNOSIS CODE: <input style="width: 90%;" type="text" value="Z5900"/>	DIAGNOSIS DESCRIPTION: <input style="width: 90%;" type="text" value="Homelessness unspecified"/>
SECONDARY DIAGNOSIS: (No decimal point needed) <input style="width: 90%;" type="text" value="Search diagnosis based on diagnosis code or its description"/>	SECONDARY CODE: <input style="width: 90%;" type="text"/>	SECONDARY DESCRIPTION: <input style="width: 90%;" type="text"/>

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
H0014	Alcohol and/or drug scvcs; ambulatory detoxification	U6			0	1	0	Edit Delete

[Add New Service Code](#)

A Community Supports (CS) TAR **must always** have a CS Referral Form attached via provider portal:

Attachments:

Attachments: 0

Attach supporting documentation here.

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.

[Submit eTAR](#)

Asthma Remediation: Two months – End date should be two months from the start date.

PHC - eEligibility

Date of Service will **always** be the start date of the TAR

Member Search

1 Date of Service:

Social Security Number:

2 CIN #:

Last Name:

First Name:

Date of Birth:

Search Help!

Below is the search Criteria with the Date of Service

- 1.SSN (for e.g.: 999999999)
- 2.CIN (for e.g.: 999999999)
- 3.Last Name AND First Name
- 4.Last Name AND DOB (for e.g. DOB: 01/01/2015)

Member Identifier/ CIN	Last Name	First Name	Gender	Date of Birth	Program	Actions
			Male		Medi-Cal	<input type="button" value="Select"/>

Click on Select, providers will review eligibility for services. Community Supports TARs will always be Outpatient eTARs. You will see this landing page below once clicked on Submit Outpatient eTAR:

TAR Start & End Dates

START DATE: END DATE:

TAR TYPE: *

Please attach Prescription, MD Order, and Clinical Notes providing medical justification for the requested service.

SERVICE PROVIDER DETAILS:

PROVIDER FAX# (ON FILE):

PATIENT CURRENT LOCATION: *

SELECT PROVIDER: *

SERVICE PROVIDER ADDRESS:

PREFERRED RETURN FAX#:

IS URGENT:

Service Details should be entered and appear exactly as below:

Diagnosis Details & Medical Justification

PRIMARY DIAGNOSIS: * (No decimal point needed) <input type="text" value="Z599"/>	DIAGNOSIS CODE: <input type="text" value="Z599"/>	DIAGNOSIS DESCRIPTION: <input type="text" value="Problem related to housing and economic circumstances, unsp"/>
SECONDARY DIAGNOSIS: (No decimal point needed) <input type="text" value="Search diagnosis based on diagnosis code or its description"/>	SECONDARY CODE: <input type="text"/>	SECONDARY DESCRIPTION: <input type="text"/>

Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges	
S5165	HOME MODIFICATION, PER SVS	U5			0	1	0	Edit Delete

[Add New Service Code](#)

A Community Supports (CS) TAR **must always** have a CS Referral Form attached via provider portal. Please ensure to also provide:

- Asthma Remediation Trigger Form

Attachments:

Attachments: 0

Attach supporting documentation here.

Disclaimer: Authorization does not guarantee payment. Payment is subject to patient eligibility at the time service is rendered.

Note: Clicking Submit TAR is equivalent to signature.

[Submit eTAR](#)