



Medical Treatment Authorization Request (TAR) Form

Partnership HealthPlan of California
4665 Business Center Drive
Fairfield CA 94534
(707) 863-4133 or (800) 863-4144
FAX # (707) 863-4118
PartnershipHP.org

To expedite your request, please use our Provider Online Service Portal at <https://provider.partnershiphp.org/UI/Login.aspx>.
If you don't currently have access to our Portal, please reach out to our Provider Education Team at esystemssupport@partnershiphp.org for assistance.

Provider Use Only

Rendering / Servicing Provider: _____

Rendering Phone Number: _____ Rendering Fax Number: _____

Servicing Address: _____ Group NPI: _____

City, State, Zip: _____ Tax ID: _____

Outpatient (23 hours or less) Durable Medical Equipment Inpatient (24 hours or more)

The TAR is: _____ If Inpatient, place of Service (POS): _____

Urgent (72 hours): Potentially life-threatening condition Admit Date: _____

Routine (Up to 7 calendar days): Important to health; not life threatening

Member Name: _____ Member CIN: _____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Gender: _____

Diagnosis Description:

ICD 10 CM Codes:

Medical Justification:

Services Requested	CPT Code / HCPC (Required)	Modifiers	Quantity	Charged

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.

Requesting Dates of Service

Signature: _____ Date: _____

Start Date: _____

End Date: _____

Name / Title: _____

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