Community Health, Inc.
Drug Free Treatment Authorization Request (TAR)

Oregon Health Plan

To be completed by ODS: Authorization Number | Date Issued

Client Information

Name: Last | First | M.I.

ODS ID Number

Adress: Street/P.O. Box

City/State | ZIP Code

Phone

Gender ☐ Male ☐ Female / SSN / DOB

Service Provider Information

Agency

Date

Phone | Fax

Contact Person

Clinical Information

ICD9 diagnosis name(s)

ICD9 diagnosis code(s) (list individually, primary first)

Date this treatment episode began

Date authorization to begin (if different)

Is client a treatment transfer client/or a health plan transfer? ☐ Yes ☐ No

If yes, name of agency or health plan transferring from (no break in service)

Medical Appropriateness Assurance

Client meets DSM IV diagnostic criteria for substance abuse or dependence: ☐ Yes ☐ No

Client meets ASAM PPC-2R approved level of care: ☐ I ☐ II ☐ III

Client place at level: ☐ I ☐ II

Please explain difference in placement

Request for Authorization (Mark appropriate choice)

1 ____ Subsequent Standard

2 ____ Exception (To request additional time/money if agency has current authorization for client. Include clinical summary, OMHAS/ASAM continued stay criteria and updated treatment plan to support request for additional treatment.)

Please provide the following: financial worksheet attached specifying services to be provided.

Requested Authorization amount $_____

Requested period for authorization: number of months ☐ 1 ☐ 2 ☐ 3 from: to:

INSTRUCTIONS: Please check client's eligibility with ODS prior to submitting a TAR.

503.265.2938
1.888.474.8538
Fax 503.670.8349.

OHP 01/2006