Community Health, Inc.
Synthetic Opiate Treatment Authorization Request (TAR)

Oregon Health Plan

To be completed by ODS: Authorization Number		Date Issued
Client Information		
Name: Last	First	M.I.
Medicaid/OHP 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 authorization to begin		
Is this client a new enrollee to your program? ☐ Yes ☐ No		
If yes, name of agency or health plan transferring from (no break in service)		
Date of patient's last dose at other agency		
As reported by (name of individual representing other agency)		
If no, is this for continued treatment of a current client? ☐ Yes ☐ No		
Length of treatment requested: ☐ 3 months ☐ 6 months ☐ 12 months		

Remember to include the following clinical documentation if requesting continued treatment (re-authorization):

1. Evidence of urine drug-screen results from the previous six months.
2. Signed copy of the most recent continued care justification summary (ASAM)

By signing below, this agency ensures that the identified client meets all clinical criteria for treatment and that the service authorization requested meets medical appropriateness criteria.
SIGNATURE OF AUTHORIZED REPRESENTATIVE x

Benefits are based on current eligibility at the time the authorization was submitted. Before providing services, provider shall verify member eligibility by telephone.

INSTRUCTIONS: All items on this form must be complete in order to issue an authorization number.

503.265.2938
1.888.474.8538
Fax 503.670.8349.

OHP 01/2006