## MULTNOMAH MENTAL HEALTH

## TREATMENT AUTHORIZATION REQUEST (TAR) FORM

## Fax to (503) 988-3137 or Send via Secure Email to URTEAM@MULTCO.US

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Name:                   DOB:

 Last First Middle initial *(Date format: M/D/YYYY)*

Member Address:

 Street Address

             Phone:

 City, State Zip Code

Gender:       SS#:       ICD-10 Diagnosis #:

**ELIGIBILITY INFORMATION**

**[ ]**  Health Share of Oregon Multnomah Mental Health Level of Care (A,B,C,D):

[ ]  Medicare Primary Medicaid Co-Pay Locus Level: (if applicable) [ ] 2 [ ] 3 [ ]  4

[ ]  AMHI Funded Medicaid/OHP #:

[ ]  Third Party Insurance *(if any):*

Carrier      , group/policy #      and effective date

**PERSON SUBMITTING REQUEST**

Requester Name:       Phone:       Fax:

 Email:

**PROVIDER REQUESTED**

Provider/Agency:       Phone:       Fax:

Address:

Contact person:       Phone:       Fax:

Email:

Service requested:

[ ]  Assessment only $       *(Fill in the amount)* ***OR*** [ ] Treatment total amount requested $:

**TREATMENT SERVICES REQUESTED**

Requested start date:       Projected end date:

**Submit clinical documentation with all treatment authorizations requests.**

*(Please check one box only)*

[ ]  Non Par       Provider name:

[ ]  Outpatient [ ]  Waitlist ICM

[ ]  Additional Funding Request [ ]  Transition Aged Youth (TAY)

[ ]  Dialectical Behavior Therapy [ ]  St. Vincent/Providence Day Treatment

[ ]  CORE/ACT [ ]  St. Vincent Eating Disorder Treatment

[ ]  IDDT Intensive Case Management (ICM) [ ]  Therapeutic Day School/Serendipity

[ ]  Strength Based ICM [ ]  Out of Area BRS Level Mental Health Services

[ ]  Other, specify:       [ ]  Providence Home Health Services

**INSTRUCTIONS FOR EXCEPTIONAL NEEDS TREATMENT AUTHORIZATION REQUEST**

**(TAR)**

Please be aware that insurance eligibility may change from month to month. Providers are to verify client enrollment prior to each session and before submitting a TAR.

Fax or secure email completed TAR with clinical documentation to Health Share of Oregon Multnomah Mental Health. At any point in the course of treatment, further funds may be requested based on medical necessity. Make sure the TAR is fully completed. Be sure to include:

• Member identification information including Medicaid/OHP #, or other 3rd party insurance policy #

• Provider information

• Axis I diagnosis for an OHP covered condition

• Type of authorization requested (please check appropriate box)

• Requested authorization start date

• Total dollar amount for requested mental health services

You will receive notification regarding incomplete requests. Provider will receive notification of authorization approval, denial, or the need for additional clinical material within 14 days of receipt of a complete TAR.

All mental health assessments and on-going treatment services for non-participating providers and for all services identified in “Treatment Services Requested” section must be pre-authorized. Submit the TAR with mental health assessment and treatment plan of preauthorization for on-going treatment services.

For information regarding authorizations for AMHI funded clients, please call Member Services (503) 988-5887 and request to speak with the AMHI supervisor.

**Reimbursement and Claims Submission**

Health Share of Oregon Multnomah Mental Health (HSOMMH)/Multnomah County AMHI will pay contracted providers according to the contract terms agreed upon between provider and HSOMMH/Multnomah County AMHI for services provided to HSOMMH members who are enrolled in HSOMMH on the date of service. When HSOMMH is the primary payor, provider will submit detailed claims using the CMS 1500 claim form to PH Tech within 90 days from the date health care services were delivered. When the member is covered by other insurance and HSOMMH is not the primary payor, provider will submit detailed claims using the CMS 1500 claim form and the primary payor EOB to PH Tech within 12 months from the date health care services were delivered. Claims later than these time frames may be denied. Provider shall submit claims to:

PH Tech

PO Box 5490

Salem, OR 97304

Attn: Health Share of Oregon Multnomah Mental Health Claims Processing

Provider must use due diligence in collecting third party resources to offset the cost of the member's mental health treatment. Provider shall make all reasonable efforts to collect from payors (specifically government programs, commercial insurance, or other third party payors, private or otherwise), for all eligible and contracted costs associated with the member's care. For members with dual eligibility, provider must bill and follow the rules of primary insurance provider (including any authorization requirements) prior to submitting claims for Health Share of Oregon Multnomah Mental Health payment.