TAR UPDATE TRANSMITTAL FORM 18-3

- **FROM:** County Mental Health

- **RETURN TO:** Xerox State Healthcare, LLC
  P.O. Box 15200
  Sacramento, CA 95851-1200

1. On this form fill in the corrected information only.
   DO NOT fill in items which will not change.

2. If you wish to "Cancel" the TAR: Write in blue or black ink "Cancel" (comments/explanation)

3. Fill in the original TAR Control Number, Date Change Effective, and sign at the bottom of this form.

4. ATTACH a copy of the original TAR to this form showing corrections in red and mail to the address above.

PROVIDER: YOUR REQUEST IS:

- [ ] APPROVED AS REQUESTED
- [ ] APPROVED AS MODIFIED SEE COMMENTS BELOW
- [ ] DENIED REASON AND ALTERNATE TREATMENT PLAN RECOMMENDED
- [ ] DEFERRED
- [ ] JACKSON VS RANK PARAGRAPH CODE

ID NO ____ DATE ____

COMMENTS/EXPLANATION

APPROVED CARE TYPE

- [ ] ACUTE
- [ ] ADMIN DAYS
- [ ] MENTAL HEALTH STAY

ADMISSION DATE ____

MEDICARE [ ]

STATUS

DAYS OF THIS HOSPITALIZATION ARE DENIED ____

DATE OF DAYS DENIED

	RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION E1D02(H)	FROM DATE	TO DATE	AUTHORIZATION IS VALID FOR SERVICES PROVIDER

OFFICE	ORIGINAL/ADMIT TAR CONTROL #	BY: COUNTY MENTAL HEALTH CONSULTANT	DATE CHANGE EFFECTIVE / /