



Transforming Lives. Building Community Well-Being.

Trillium Treatment Authorization Request (TAR)

Member's Name:															
Social Security #:	DOB:	LOCUS					1	2	3	4	5	Composite Score	LOC Recommendation		
Current Address:		I. Risk of Harm													
City/State/Zip:		II. Functional Status													
Medicaid #:	- - <input type="checkbox"/> None	County (Medicaid Eligibility):		III. Co-Morbidity											
Attending Provider:		IV. a. Recovery Environment. (Support)													
Legal Guardian: <input type="checkbox"/> None <input type="checkbox"/> Parent <input type="checkbox"/> DSS <input type="checkbox"/> Other:		V. b. Recovery Environment. (Stress)													
Name:		VI. Treatment and Recovery History													
DIAGNOSES:		VII. Engagement													
Primary ICD-10: _____		COLOCUS					1	2	3	4	5	Composite Score	LOC Recommendation		
Additional ICD-10: _____		I. Risk of Harm													
Additional ICD-10: _____		II. Functional Status													
Additional ICD-10: _____		III. Co-Morbidity													
Medical Diagnosis (es): _____		IV. a. Recovery Environment. (Support)													
		IV. b. Recovery Environment. (Stress)													
		V. Resiliency and Treatment History													
		VI. a. Acceptance/Engagement (C&Y)													
		VI. b. Acceptance/Engagement (Parent/PS)													
DATE OF INITIAL ASSESSMENT and/or Subsequent Assessments prior to referral: _____		COMMENTS													
<input type="checkbox"/> MH <input type="checkbox"/> SA <input type="checkbox"/> IDD or Other Related Condition <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary															
<input type="checkbox"/> Initial Request <input type="checkbox"/> Reauthorization <input type="checkbox"/> Discharge <input type="checkbox"/> ** EXPEDITED **															
SIS or NC SNAP <input type="checkbox"/> Overall Level of Eligibility Support Score: _____ Date: _____															



ASAM Patient Placement Criteria Adult/Adolescent (See ASAM criteria for placement considerations)							
	I	II.1/5	III.1	III.3	III.5	III.7	IV
I. Withdrawal/Intoxication							
II. Medical Complication							
III. Behavioral/Emotional Cognitive Complication							
IV. Readiness for Change							
V. Relapse/Continued use or problem potential							
VI. Recovery Environment				<input type="checkbox"/>			
Placement Recommendation:							

SUBSTANCE USE						
Drug of Choice <input type="checkbox"/> N/A	Age of 1 st Use	Route of Usage	Frequency	Amount	Date of Last use	
Primary:	Years			Per		
Secondary:	Years			Per		
Tertiary:	Years			Per		
Other:	Years			Per		

MEDICAL: Current Primary Care Physician Name: _____ Signed Release to Primary Care Physician? Yes No
 Medically Compliant Non-compliant

Comments:

CURRENT MEDICATIONS	Current Regimen	# of months	CURRENT MEDICATIONS	Current Regimen	# of months
mg		<input type="checkbox"/> <1 <input type="checkbox"/> >1	mg		<input type="checkbox"/> <1 <input type="checkbox"/> >1
mg		<input type="checkbox"/> <1 <input type="checkbox"/> >1	mg		<input type="checkbox"/> <1 <input type="checkbox"/> >1
mg		<input type="checkbox"/> <1 <input type="checkbox"/> >1	Other:		<input type="checkbox"/> <1 <input type="checkbox"/> >1

Allergies:

Reason for Admission, Continued Stay or other comments

REQUEST FOR SERVICE								
Service Description & Code	Funding Source	Frequency	Duration	Start Date	End Date	Provider Site	UM ACTION	Units Approved
							<input type="checkbox"/> Approved <input type="checkbox"/> Denied-Pt <input type="checkbox"/> Denied-All	
							<input type="checkbox"/> Approved <input type="checkbox"/> Denied-Pt <input type="checkbox"/> Denied-All	
							<input type="checkbox"/> Approved <input type="checkbox"/> Denied-Pt <input type="checkbox"/> Denied-All	
Clinician Name/Contact Number:			Requesting Provider:				Date:	
Utilization Management Use Only								
UM COMMENTS:								
Date TAR Received:								
Assigned UM Care Manager:								
Utilization Management Care Manager:								

Treatment authorization requests should be submitted via secure email to UM@TrilliumNC.org. These requests should be encrypted including all necessary clinical attachments per authorization guidelines. Trillium will use the standard authorization time frames when processing these requests. Trillium will enter authorization requests received via email for the provider agency.