blue california
Promise Health Plan

Intermediate Care Facility – Developmentally Disabled

Treatment Authorization Request

Dear Provider,

Thank you for contacting Blue Shield of California Promise Health Plan (Blue Shield Promise). Below is the Intermediate Care Facility – Developmentally Disabled (IDF/DD) Treatment Authorization Request (TAR) form.

The following information is required, along with the below TAR form, when requesting approval for ICF/DD.

- Durable Power of Attorney (DPOA) if any
- Certification for Special Treatment Program Services form HS231

If you have questions or need assistance with this form, please contact the Long-Term Care Department via phone at (855) 622-2755, Monday through Friday, 8 a.m. to 4:30 p.m., or by fax at (844) 200-0121.

Sincerely,

Blue Shield Promise
Long-Term Care Department

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association

Intermediate Care Facility – Developmentally Disabled

Treatment Authorization Request Form

Initial **Reauthorization** **Bed Hold / LOA** **Discharge Notice**

Patient last name:		Patient first name:
Gender: male female nonbinary		Date of birth:
Patient identification number:		Client identification number (CIN):
Patient mailing address:		
City:		ZIP code:
Patient phone:		
Patient diagnosis:		
Admission / Reauthorization	Start date:	Discharge date, if applicable:
Bed hold / LOA, if applicable	Start date:	End date:

Physician name:	
National provider identifier (NPI):	
Physician office phone:	Physician office fax:
Physician mailing address:	
City:	ZIP code:

Intermediate Care Facility type – Choose one of the following		
ICF/Developmentally disabled (DD)	ICF/DD – Habilitative	ICF/DD - Nursing

Facility name:	
Facility NPI:	
Facility contact name:	
Facility phone:	Facility fax:
Facility mailing address:	
City:	ZIP code:

Fax the completed form to Blue Shield Promise Long Term Care Department at (844) 200-0121.