



**UNITED STATES PUBLIC HEALTH SERVICE
DIVISION OF IMMIGRATION HEALTH SERVICES (DIHS)
TREATMENT AUTHORIZATION REQUEST (TAR)**



Immigration Health Services
1220 L Street, NW · Suite #500 · Washington, D.C., 20005
Phone 1-888-718-8947 · Fax 1-866-256-8172

Is this request a TAR APPEAL (Please circle one*) YES NO

If YES, it is required that you provide the TAR NUMBER you are appealing: _____

Detention Facility*: _____ Phone#*: _____

Address*: _____ Fax#*: _____

City*: _____ State*: _____ Zip*: _____

DETAINEE INFORMATION

Last Name*: _____ First*: _____

Alien ID*: _____ Date of Birth*: _____ Sex*: Male Female

Camp Arrival Date*: _____ Country of Origin*: _____

REASON FOR REFERRAL REQUEST

Diagnosis/Symptoms*: _____

Course Of Treatment*: _____

_____ CPT/CDT: _____

ATTESTATION OF DETAINEE CUSTODY

I _____ as of _____ attest that the information provided on this
(PRINT NAME*) (TODAY'S DATE*)

TAR form is correct to the best of my knowledge and that the detainee is not a U.S. Citizen and is/was in custody of the (check one*):

US Border Patrol (BP) – Please circle one of the following and provide: FIN or Event# or Log# _____

US Immigration and Customs Enforcement/Detention and Removal (ICE/DRO)

US Office of Refugee Resettlement (ORR)

from _____ to _____
(CUSTODY BEGINNING DATE*) (CUSTODY END DATE*)

(SIGNATURE*) (TITLE*) (PHONE NUMBER*)

PROVIDER OF MEDICAL CARE AND OTHER SERVICES

Provider's Name**: _____ Specialty*: _____

Provider's Phone Number**: _____ Provider's City**: _____ Provider's State**: _____

DIHS AUTHORIZATION ACTION

(To be completed by DIHS ONLY)

DIHS Managed Care Coordinator (MCC): _____ Date: _____

MCC TAR Action: Approved Denied Pended (Signature)

MCC Comments: _____

Please provide a copy of the "Approved" TAR to the Health Service Provider. Non-emergent health services will not be paid without an approved TAR issued prior to health services being rendered. Emergency health services require TAR submittal within one business day after being sought. A separate TAR will be required for health services beyond and outside the scope of the original authorized TAR. For health care claim status inquiries, call 1-800-479-0523. **To appeal a TAR decision** of DIHS to not authorize a service, a detention facility must submit a TAR Appeal through the TAR process and include the following information: a) "TAR Appeal", b) TAR number and other information from TAR being appealed, c) requested action, and c) justification for the requested action. **For further guidance** and information, please visit our website at: www.icehealth.org or contact the DIHS' Managed Care Coordinators at 1-888-718-8947, M – F, 8AM – 6 PM EST.

***Failure to complete required fields will result in an inability of DIHS to process TAR.**

****Required when reason for TAR submittal is for emergency health services.**