

Philadelphia Behavioral Health System: Community Behavioral Health
801 Market Street/7th Floor/Philadelphia, PA 19107
215-413-3100

BEHAVIORAL HEALTH REHABILITATIVE SERVICES
PACKET SUBMISSION COVER LETTER

Date: _____

To: CBH Clinical Management – BHRS Team

From: _____ Contact Person

_____ Agency _____ CBH Provider #

_____ Phone _____ Fax

Re: _____ Child/Adolescent Name

MA #

DHS: Custody Supervision Name of worker: _____

TYPE OF PACKET (please check):

Behavioral Health Rehabilitative Services

SBBH/CARE/TESS/Nurture

Other (specify)

Response to Insufficient Documentation

Addendum

Partial Hospitalization/After School and Weekend Program

TIME PERIOD REQUESTED: _____

DATE INTERAGENCY MEETING WAS HELD: _____

TYPE OF EVALUATION CBE - MD CBE – Non MD CBR - MD CBR – Non MD
 Addendum

NAME OF SCHOOL THAT CHILD ATTENDS _____

ADDRESS OF SCHOOL _____

Contact _____ **Telephone Number** _____

COMMENTS:

