

**BEHAVIORAL HEALTH SYSTEM
COMMUNITY BEHAVIORAL HEALTH**

BHRS Authorization Request

Re: _____ **MA#:** _____

To: _____ **Provider #:** _____
(Name of Agency)

Phone: _____ **Fax Number:** _____

Date Packet Received: _____ **Date Packet Reviewed:** _____

Packet Information

All required documentation included in the packet
 Required documentation missing in the packet: _____

Result of Review

Services Approved as Requested *(Please note: authorization is contingent upon CBH Medicaid Eligibility)*
 Insufficient Documentation; unable to review request for services.
 Packet pended; *(Providers have fifteen (15) business days to respond before packet is voided).*
 Request for services has been sent to OMHSAS for Impartial Review on _____

Additional Comments: _____

Services Authorized

Services Requested	Hours Requested	Hours Authorized	Authorization Number
Group TSS			
TSS			
TSS Aide			
Behavioral Specialist – Ph.D			
Behavioral Specialist - BS			
Mobile Therapy			
Case Management			
Other			

Period Requested: _____ **Period Authorized:** _____

SERVICE MANAGER: _____ **DATE COMPLETED:** _____