CBH BHR SERVICES REQUEST FORM

Type of Service: (check one) BHRS ☐

RTF ☐

Date of Submission: _____

Date CBH Received: _____

Client Name	CIS#	Soc. Sec.#	Children Only DHS Involvement Yes	No	Special Education Yes	No	Living Arngmt Code	Voc. Educ. Code	Requested Service(s) TSS, TSS Aide, Case Management, MT, BSC, etc.	Requested Auth Service Start Date	Requested Auth Service End Date	# of Units	Initial or Continued Stay Request (I or C)	Prim. Axis I Dx	Sec. Axis I Dx	Priority Group Code

Agency Name/Contact: _____

CBH Provider #: _____

Fax #: _____

Telephone #: _____

March, 2000

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