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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name** | **CIS#/MA#** | **Soc. Sec #** | **New or Transfer** | **Requested LOC Code** | **Date Referral Received**  | **Requested Auth Service Start Date** | **Requested Auth Service End Date** | **Primary Diagnosis** | **Secondary Diagnosis** |
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**CBH Case Management Service Request Form**

\*Default number of units to request is 1.

\*Please submit **separate** forms for adult and child cases.

Provider Name/Provider Number: Provider Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Point of Contact: Provider Phone Number: \_\_\_\_­­­­ \_\_\_\_\_\_\_\_\_\_

Requests for TCM authorizations should be sent to CBH Operations Support Services (OSS) at CBHauths@phila.gov and TCM.CMreferrals@phila.gov or faxed to 215-413-7683.

For questions concerning completion of this form, please contact Lazette Gray @ 215-413-8580.