# San Mateo County
# Behavioral Health and Recovery Services
# Therapeutic Behavioral Services
# Utilization Request Form (H0046 Procedure)

Distribution: Original to TBS chart; Copy to QI; Copy to MIS Specialist

For billing use only:
**Utilization Request#:_____**

**Date_____ TBS Provider_____ Provider #_____**

**Client Name_____ DOB_____ MH#_____**

| **TBS Start Date** | **TBS End Date** | **Hours/Week Approved** | **Total Hours Received** |
|---|---|---|---|
| (Assessment) | | | |
| | | | |
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* Requests should be submitted to UR committee 7 days prior to the end date of previous utilization period.

**Request for TBS Services** (to be completed by TBS Provider)

Number of hours per week requested _____ Number of days requested _____

Period requested: Start Date _____ End Date _____

*Note: Initial review must be accompanied by completed Assessment, Treatment Plan and Progress Notes. Subsequent requests must be accompanied by Progress Summary, revised Treatment Plan (if applicable) and Progress Notes.*

_____ _____ _____ _____
Staff Signature Date Supervisor's Signature Date

**Approval for TBS Services** (to be completed by San Mateo County)

☐ TBS is approved for: up to _____ hours per week, and up to _____ days

Start Date _____ End Date _____ Total Hours _____

Date request received _____

☐ TBS Services not approved, NOA required
☐ TBS Services request modified, NOA required

Additional documentation or information requested by UR committee:

_____ _____
SMC BHRS Staff Signature Date