Group Health Cooperative of South Central Wisconsin

GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN

Request for Ongoing Behavioral Health Services Form (BH102)

Fax to GHC-SCW Care Management at (608) 831-6099

Date of Request: _____ Member's GHC-SCW #: _____

Member Name: _____ DOB: _____

Treating Provider: _____ Provider NPI #: _____

Clinic Name: _____ Clinic Tax ID #: _____

Phone #: _____ Fax #: _____

Service Type: ☐ Individual ☐ Group ☐ Couple ☐ Family ☐ Medication Management

Total # of Sessions Provided: _____ Additional # of Visits Requested: _____

Date Last Seen: _____ Date of Next Scheduled Visit: _____

Current Treatment Visit Frequency: _____

ICD10 Code/DSM-5 Diagnosis: _____

Anticipated Discharge Date/End of Treatment: _____

Current Information:

Symptoms: _____

Functional Impairments: _____

Safety Concerns: _____

Contributing Biopsychosocial Factors: _____

Treatment modality/approach (e.g., Cognitive Behavioral Therapy (CBT), Exposure Therapy, Dialectical Behavioral Therapy (DBT), etc.): _____

Measurable Treatment Goals:	**# of Visits to Complete Goal:**	**Document Progress Made Toward Goal:**

Medications: _____

Other Behavioral Health Providers: _____