## 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 Client Name		Provider #	
		DOB MH#	
TBS Start Date	TBS End Date	Hours/Week Approved	Total Hours Received
(Assessment)			
* Requests should	be submitted to UR committee	e 7 days prior to the end date o	f previous utilization period.
Re	equest for TBS Services	<u>s (</u> to be completed by TBS	S Provider)
Number of hours per we	eek requested	Number of days	requested
Period requested: Star	t Date	End Date	
Staff Signature	Date	Supervisor's Signature	Date
<u>Appr</u>	oval for TBS Services (	to be completed by San N	Mateo County)
TBS is approved fo	or: up to ho	ours per week, and up to _	days
Start Date	End Date	Tota	l Hours
Date request received			
□ TBS Services not ap □ TBS Services reques	proved, NOA required st modified, NOA required	d	
Additional documentation	or information requested by	y UR committee:	