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:_ _____