CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

# Therapeutic Behavioral Services (TBS) Provider Request For Payment & Authorization

NAME / MRN

Date: _____

_____
**TBS Provider Contact/Supervisor**

_____
**Primary County/CBO Service Provider (Point Person)**

_____
**Name of TBS Provider Agency**

_____
**Referring County Clinic/CBO**

_____
**Contact Number**

_____
**Contact Number / Fax Number**

❒ Contact was made this month with the point person.
❒ This is a new point person.

DATE ASSIGNED/TBS START DATE: _____

**AUTHORIZATION REQUESTED FOR:**

❒ Preliminary Treatment Plan
❒ Final Treatment Plan
❒ Addendum Plan
❒ Monthly Report
❒ Medi-Cal Verification through the month of: _____

## HOURS/WEEKS OF SERVICE:

NUMBER OF HOURS/MINUTES OF SERVICE TO DATE: _____ : _____

NUMBER OF WEEKS OF SERVICE TO DATE: _____

**If services exceed 16 weeks, please document justification for continued authorization in the Plans for Fade-out section of the Monthly Report for review.**

MONTH/HOURS/MINUTES REQUESTED: _____: _____:_____

MONTH/HOURS/MINUTES REQUESTED: _____: _____:_____

**I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT THE INFORMATION FORWARDED IS ACCURATE AND THE CONSUMER MEETS ALL MEDICAL/SERVICE NECESSITY CRITERIA.**

_____ _____
Signature of Authorized Agency Representative Date

For questions about reports or authorized hours contact TBS at:
Main: 925-521-5740
Fax: 925-646-5870
By Encrypted Email only: ContraCostaTBS@hsd.cccounty.us