REQUEST FOR CONCURRENT REVIEW (RCR)
SUBMIT TO MENTAL HEALTH PLAN TO:
Authorization Services
Alameda County Behavioral Health Care Services
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

Phone (510) 567-8141 FAX (510) 567-8148

Client Name: _____ (press "Tab" on keyboard)
Client DOB: _____
Client CIN or SSN: _____ (press "Tab" on keyboard)
Provider Name: _____ (press "Tab" on keyboard)
Agency, if applicable: _____
Provider Phone: _____

CLIENT PLAN UPDATE

Complete in collaboration with client whenever possible.

General Instructions:

- This form is available online at www.acbhcs.org - BHCS Providers - Forms - Authorization, or http://www.acbhcs.org/providers/Forms/Forms.htm#Authorization.
- Please press "tab" on your keyboard each time after typing in (1) Client Name, (2) Client CIN or SSN, and (3) Provider Name, in the box above. The same information will appear on the next page.
- To save a copy of the form onto your computer, after clicking on the RES or RCR link, select "Save" when "File Download" window appears.
- If client has a Client Information Number(CIN), the CIN must be used, per State regulations. (CIN is on Medi-Cal card and AEVS)

1. **Progress toward mental health objectives since last authorization** *(If little or no progress, indicate why):*

   _____

2. **Medical Necessity for Services** (Per clinician's current assessment, describe the medical necessity for mental health services. Indicate how the client's current symptoms cause specific problems in daily functioning that your services will address.)

   _____

3. **Next six-month specific mental health objectives (observable or measurable) to support improved functioning:**

   _____

4. **Current psychiatric medications, dosage, and frequency. Changes in diagnosis and/or treatment since last authorization:**

   _____

5. **If applicable, please respond to questions from last Authorization Reviewer here**:

   _____

6. **Change in Special Needs?**

   _____

7. **Updated Strengths and Resources**

   _____

Client Name:
Client CIN or SSN:
Provider Name:

8. Service Request for Authorization *Please use one line for each service. (NOT REQUIRED FOR HPAC)*

CPT Service Code (per your rate sheet)	**Service Description** (per your rate sheet)	**Frequency of Service**	**Diagnosis Code(s) Addressed**
Example: X9502	Individual Therapy	1x/week	296.22

9. If closing case,

Reason for closing: _____

Date of last session: _____

Referrals made: _____

***CLIENT'S SIGNATURE:_____ Date_____**
Legal Representative's signature., if required:_____ Date_____
Specify Legal Rep.'s Relationship (e.g., parent, guardian, conservator): _____
If client/legal rep. verbally agreed with Client Plan but declined to sign, provide the Date: _____
If client/legal rep. disagrees with Plan, provide Reason/Date: _____
Client's signature required above AND client must be offered copy of Client Plan page unless clinician believes client's condition would suffer. If so, provide
Reason/Date:_____

Provider/Clinician information is required on the line below.

_____

Clinician's printed name **Signature with discipline (e.g., MFT, LCSW, MD)** **Date**

If Clinician is not licensed, Licensed Supervisor's information is required on the line below:

_____

Lic. Supervisor's printed name **Signature with discipline (e.g., MFT, LCSW, MD)** **Date**