

**Ohio Department of Health • Bureau for Children With Medical Handicaps**

P.O. Box 1603, Columbus, Ohio 43216-1603

Phone (614)466-1700 FAX (614)728-3616

## Interim Request for BCMH Services

|                        |                  |
|------------------------|------------------|
| Date                   |                  |
| Child's name           | BCMh case number |
| Birthdate              | County           |
| Parents' names         |                  |
| Managing physician     |                  |
| Person completing form | Phone number     |

**Directions: Please type one form for each child for whom you are requesting services and submit to the above address. Be specific as to type of service/equipment, date services need to begin, units of services needed and name and address of BCMH provider.**

### Services requested

| Type of service | Date service is needed | Units | Provider name and address |
|-----------------|------------------------|-------|---------------------------|
|                 |                        |       |                           |
|                 |                        |       |                           |
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**Statement of medical necessity for requested service is required.**

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|---------------------------------|------|
| Signature of managing physician | Date |
|---------------------------------|------|