

**Ohio Department of Health • Children With Medical Handicaps Program (BCMh)**

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 of Residence
Parents' names		
Managing physician		
Person completing form		
Email of 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	Provider name and address

**Statement of medical necessity for requested service is required.**

Supporting documentation attached.


Signature of requesting BCMh provider (MD / DO / DDS / APN)	Date
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