



Concurrent Review Form Behavioral Health Services

Mail to: Behavioral Health Services, c/o CDPHP, 500 Patroon Creek Blvd., Albany, NY 12206-1057,
fax to (518) 641-3601, or submit online by logging into www.cdphp.com.

All fields must be completed and legible or the request cannot be processed. Approval of this form does not guarantee payment of benefits. Final determination is based on eligibility, authorization rules, and plan limits.

Date of Request: _____

Patient Information

Last Name: _____ First Name: _____

Member ID#: _____ Date of Birth: _____

Patient Signature: _____

Practitioner Information

Practitioner Name: _____ Phone #: _____

Provider # or NPI: _____ Fax #: _____

Practitioner Signature: _____

Facility Information

Agency/Clinic: _____

Admission Date: _____

DSMV Diagnosis (please include both psychiatric and medical diagnoses): _____

Program Request:

ACT PROS (Continuing Active Rehabilitation) Continuing Day Treatment PHP/IOP

GOAL & OBJECTIVE STATUS	New	Continued	Discontinued	Attained	Revised
Goal #1:	[]	[]	[]	[]	[]
Objective #1	[]	[]	[]	[]	[]
Objective #2	[]	[]	[]	[]	[]
Objective #3	[]	[]	[]	[]	[]
Evidence of progress, barriers, and/or rationale for attainment, addition of new goal/discontinuation of goal, revision or continuation:					
Summary of Progress:					

GOAL & OBJECTIVE STATUS	New	Continued	Discontinued	Attained	Revised
Goal #2:	[]	[]	[]	[]	[]
Objective #1	[]	[]	[]	[]	[]
Objective #2	[]	[]	[]	[]	[]
Objective #3	[]	[]	[]	[]	[]
Evidence of progress, barriers, and/or rationale for attainment, addition of new goal/discontinuation of goal, revision or continuation:					
Summary of Progress:					

GOAL & OBJECTIVE STATUS	New	Continued	Discontinued	Attained	Revised
Goal #3:	[]	[]	[]	[]	[]
Objective #1	[]	[]	[]	[]	[]
Objective #2	[]	[]	[]	[]	[]
Objective #3	[]	[]	[]	[]	[]
Evidence of progress, barriers, and/or rationale for attainment, addition of new goal/discontinuation of goal, revision or continuation:					
Summary of Progress:					

GOAL & OBJECTIVE STATUS	New	Continued	Discontinued	Attained	Revised
Goal #4:	[]	[]	[]	[]	[]
Objective #1	[]	[]	[]	[]	[]
Objective #2	[]	[]	[]	[]	[]
Objective #3	[]	[]	[]	[]	[]
Evidence of progress, barriers, and/or rationale for attainment, addition of new goal/discontinuation of goal, revision or continuation:					
Summary of Progress:					

Revised/New Goal Sheet

Goal #		
Start Date:	Target Completion Date:	Adjusted Target Date: as per IAP Review Form Dated:
Desired Outcomes in Individual's Words:		
Goal (State Goal for this Assessed Need in Collaboration with the Individual Served):		
Individual's Strengths and Skills that will be Utilized to Meet This Goal:		
Description of Outside Services, Supports, and Plan of Coordination Needed to Meet this Goal:		
Potential Barriers to Meeting This Goal:		

GOAL # OBJECTIVE:					
Start Date:		Target Completion Date:		Adjusted Target Date:	
Intervention(s) / Method(s) / Action(s) (PROS-Component)	Service Description/ Modality		Frequency		Responsible: (Type of Provider)

GOAL # OBJECTIVE:					
Start Date:		Target Completion Date:		Adjusted Target Date:	
Intervention(s) / Method(s) / Action(s) (PROS-Component)	Service Description/ Modality		Frequency		Responsible: (Type of Provider)