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FAMILY STABILIZATION TEAM CONCURRENT REVIEW FORM

BEHAVIORAL HEALTH DEPARTMENT
PHONE: (413) 787-4000 EXT. 5028 FAX: (413) 233-2800

Please complete thoroughly. Send completed form to HNE Behavioral Health Department for review and decision.

MUST ENCLOSE RELEVANT CLINICAL DOCUMENTATION TO SUPPORT THIS REQUEST

Provider Name: _____ Office Phone: _____

Clinician Name: _____ Phone(s): _____

Member Name: _____ HNE ID: _____

Phase: 2A 2B 3A 3B Start Date: _____ End Date: _____

Concurrent Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Problem Area #1: _____

Progress on Treatment Goal(s): None Limited Moderate Good

Problem Area #2: _____

Progress on Treatment Goal(s): None Limited Moderate Good

Problem Area #3: _____

Progress on Treatment Goal(s): None Limited Moderate Good

Problem Area #4: _____

Progress on Treatment Goal(s): None Limited Moderate Good

Outpatient Appointments:

Therapist: _____ Appointment Date: _____

Psychiatrist: _____ Appointment Date: _____

Other Provider: _____ Appointment Date: _____

Collateral Contacts/Meetings: _____ Appointment Date: _____