

County of Los Angeles – Department of Mental Health
Local Mental Health Plan
REQUEST FOR CHANGE OF PROVIDER
CONFIDENTIAL

To request a change in your current provider, complete this form and submit it to the Program Manager's office. Every effort will be made to accommodate your request. You will receive a decision within 10 working days. If you are a Medi-Cal beneficiary seeing a private provider in the community who is not part of a county operated or county contracted program, call the Beneficiary Services Program in the Patients' Rights Office at 800-700-9996 or 213-738-4949. The Mental Health Plan cannot guarantee that your provider will be changed. If you do not receive a decision on your request within 10 working days or you disagree with the decision, you may file a formal grievance.

SECTION 1: CURRENT PROVIDER INFORMATION (clients please fill out Section 1 & 2 ONLY)

DATE: _____ SERVICE LOCATION: _____

PROVIDER NAME: _____

SECTION 2: BENEFICIARY /CLIENT INFORMATION

Client Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ Are you receiving **Medi/Cal**? Yes No

1. I am requesting a change in: Service Staff Medical Staff Program

2. Please select the reason(s) for requesting a change (this information is OPTIONAL)

- | | | |
|--|---|---|
| <input type="checkbox"/> A = Time/Schedule change | <input type="checkbox"/> F = Treatment concerns | <input type="checkbox"/> K = Uncomfortable |
| <input type="checkbox"/> B = Language | <input type="checkbox"/> G = Medication concerns | <input type="checkbox"/> L = Insensitive/ Unsympathetic |
| <input type="checkbox"/> C = Age (too old/too young) | <input type="checkbox"/> H = Lack of assistance | <input type="checkbox"/> M = Not professional |
| <input type="checkbox"/> D = Gender (male/female) | <input type="checkbox"/> I = I want previous provider | <input type="checkbox"/> N = Does not understand me |
| <input type="checkbox"/> E = Treating family member | <input type="checkbox"/> J = I want 2 nd opinion | <input type="checkbox"/> O = Not a good match |

P = Other – Please describe the reason(s) for requesting the change (this information is OPTIONAL)

R = I do not want to give a reason for my request

3. Have you discussed your concerns with your current provider? YES NO

If YES, please describe what you have done to try to resolve the problem:

I understand that I will be contacted about this request within 10 working days. I prefer to be

contacted by: Mail Telephone Email: _____

If this request is on behalf of a minor or dependent adult; are you the: Parent Guardian

Signature of Person making request: _____ Today's Date: _____

SECTION 3: RECEIPT OF CHANGE OF PROVIDER REQUEST

Received by: _____ Date: _____ Copy given to client: Yes No

SECTION 4
Clinical Data

AUTHORIZED COUNTY USE ONLY

DSM-IV

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Medications – Specify dosage and frequency: _____

REVIEWED BY: _____

DATE: _____

RECOMMENDATION: _____

Referral To: _____

Notified: _____ Date: _____

Appointment: _____

Beneficiary/Client Contacted on: _____ by: _____

<p>This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by Law. Destruction of this information is required after the stated purpose of the original request is fulfilled.</p>	<p>Name _____ IS# _____</p> <p>Facility/Practitioner: _____</p> <p>Protected Health Information (PHI) Los Angeles County – Department of Mental Health</p>
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