



**LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH**

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director



Enter Date

Enter Beneficiary's Name

Enter Address

Enter City, Enter State Enter ZIP Code

SUBJECT: REQUEST FOR CHANGE OF PROVIDER

Dear Enter Ms. or Mr. and Beneficiary's Last Name:

This is to confirm our recent conversation regarding your request to change providers. We are unable to grant your request at this time due to the following reason(s):

Enter Reason

You currently have an appointment scheduled with

Staff Name: _____

Date: _____

Time _____

If you have any questions, please contact me at Enter Phone Number.

Sincerely,

Enter Program Manager's Name

Enter Program Name

Enter Initial(s)

c:

Response Letter Sample for Change of Provider Request Not Granted
200.05 - Attachment 2