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

To request a change in your current provider, complete **Sections 1 and 2** of this form and submit it to the Program Manager's office. Every effort will be made to accommodate your request. You will receive a notice of the decision within 10 business days. If you are a Medi-Cal beneficiary seeing a private provider in the community who is not part of a County program, operated or contracted, call the Beneficiary Services Program in the Patients' Rights Office at 800-700-9996 or 213-738-2524. The Local Mental Health Plan cannot guarantee that your provider will be changed. If you do not receive a notice of the decision on your request after 10 business days or disagree with the decision, you may file a formal grievance.

SECTION 1: CURRENT PROVIDER INFORMATION

Date Requested: _____Program of Service Location: _____

Do you have an assigned Staff: ☐ Yes ☐ No ☐ Unknown If yes, to whom have you been assigned: ☐ Caseworker ☐ Therapist

☐ Psychiatrist

SECTION 2: BENEFICIARY / CLIENT INFORMATION

Client Name: _____ Birth Date: _____

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

Phone: _____ Are you receiving **Medi-Cal**? ☐ Yes ☐ No

1. I am requesting a change in: ☐ Practitioner ☐ Program of Service

2. Please select the reason(s) for requesting a change:

☐ Appointment scheduling	☐ Treatment concerns	☐ Uncomfortable
☐ Language	☐ Medication concerns	☐ Insensitive / Unsympathetic
☐ Age (too old / too young)	☐ Lack of assistance	☐ Unprofessional
☐ Gender	☐ Prefer previous provider	☐ Does not understand me
☐ Treating family member	☐ Prefer second opinion	☐ Not a good match
☐ Do not want to give a reason	☐ Cultural reasons	
☐ Other (optional):		

_____

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: _____ ☐ In-person at next appointment

If this request is on behalf of a minor or dependent adult, you are the ☐ Parent ☐ Guardian ☐ Conservator

Name of Person making request: _____

SECTION 3: RECEIPT OF CHANGE OF PROVIDER REQUEST

Received by: _____ Date: _____ Copy given to Client: ☐ Yes ☐ No

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SECTION 4: AUTHORIZED USE ONLY

Was Request Granted: ☐Yes ☐ No

If no, reason for rejection: _____

If yes, current Practitioner Name and Employee ID#: _____

If yes, new assigned Practitioner Name and Employee ID#: _____

If yes, new program of service referred to: _____

Notified Beneficiary by: ☐ Mail ☐ Phone ☐ In Person: Next appointment_____

Beneficiary / Client Contacted on: _____ By: _____

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 towhom it pertains unless otherwise permitted by Law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

IBHIS / IS #:

Program of Service:

Protected Health Information
Los Angeles County Department of Mental Health