Please submit copy in person or email copy to changeofprovider@tricitymhs.org

County of Los Angeles - Department of Mental Health

Local Mental Health Plan

REQUEST FOR CHANGE OF PROVIDER

CONFIDENTIAL

TRI·CITY Mental Health

Date ☐☐ / ☐☐ / ☐☐☐☐

For optimum accuracy, please print clearly using capital letters:

A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z

To request a change in your current provider, please submit this form 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 213-738-2524. 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.

Please answer all questions by filling in all blank areas as completely as possible and by shading in the appropriate circles.

SECTION A: BENEFICIARY/CLIENT INFORMATION

Client Name (First & Last)

Birth Date __ / __ / ____

Address (Number & Street)

City

State C A

Zip

Phone Number (Area Code First) ___ - ___ - ____

SECTION B: CURRENT PROVIDER INFORMATION

IMPORTANT: Please shade circles like this =>●

1. Service Location (Choose One):

○ 2008 N. Garey Ave

○ 1900 Royalty Dr

2. I am requesting a change in: (shade-in selection/ write name below):

○ Doctor ○ PT ○ Therapist ○ Case Manager ○ Program

3. Please completely fill in the circle next to the reason(s) for requesting a change (this information is OPTIONAL):

☐ A. Time/Schedule Change
☐ B. Language
☐ C. Age (too old/too young)
☐ D. Gender (male/female)
☐ E. Treating Family Member
☐ F. Treatment Concerns
☐ G. Medication Concerns
☐ H. Lack of Assistance
☐ I. I want Previous Provider
☐ J. I want 2nd Opinion
☐ K. Uncomfortable
☐ L. Insensitive/Unsympathetic
☐ M. Not Professional
☐ N. Does not Understand Me
☐ O. Not a Good Match
☐ P. Other - Please Describe the reason(s)for requesting the change(OPTIONAL)

☐ R. I do not want to give a reason for my request ☐ S. Cultural Reasons

4. 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 ____________

SECTION C: SIGNATURE

I understand that I will be contacted about this request within 10 working days. I prefer to be contacted by: ○ Mail ○ Telephone

x ____________________

Signature of Person Making Request

Please Print Your Name

Relationship to the Client: ○ Self ○ Parent ○ Legal Guardian ○ Conservator ○ Caregiver ○ Staff

Rec'd by(Initial and Date) ____________ __ / __ / __

Copy Given to Client: ○ Yes ○ No

MRN #

Request #: ________