

Deaconhealth options Beacon Health Options/Partnership Health Plan Primary Care Provider Referral Form



Referring Provider:			
Member Name:		Member ID #:	DOB:
Member's Preferred L	anguage:	Member Phone #:	(home)
☐ Please check to co	onfirm member eligibility was	verified	(cell)
	TO RECEIVE A CONF	FIRMATION OF THIS REFERRAL'S O	UTCOME,
PLEASE C	HECK THE BOX BELOW NO	OTING YOUR PREFERRED METHOD	AND CONTACT DETAILS.
☐ Email Address:			
☐ <u>FAX Number:</u>			
equested Referra	(please use separate for	ms for multiple referrals)	
-		II (curbside consult) with a Beacon 2 PCP progress notes for psychiat	
		ult:(date)	
Fax form to: 866	6 422 3413 OR secure email:	medi-cal.referral@beaconhealthoption	s.com
Outpatient Behavio	oral Health Services: Ref	fer members interested in therapy of SP scope. Beacon coordinates with	or medication management via
Outpatient Behavior Beacon's network was Fax form to: 866 Referral for Local of mental health provide compliance and link	oral Health Services: Refulen needs are outside PC 5.422.3413 OR secure email: Care Management: Local ders, support their transition them to community support	fer members interested in therapy of the scope. Beacon coordinates with medi-cal.referral @beaconhealthoptions behavioral health care coordination between levels of care, or engage	or medication management via county mental health. s.com n services to help link members
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