



**Beacon Health Options/Partnership Health Plan
Primary Care Provider Referral Form**



Referral Date: _____ PCP Name: _____ PCP Phone #: _____

Referring Provider: _____

Member Name: _____ Member ID #: _____ DOB: _____

Member's Preferred Language: _____ Member Phone #: _____ (home)

Please check to confirm member eligibility was verified _____ (cell)

**TO RECEIVE A CONFIRMATION OF THIS REFERRAL'S OUTCOME,
PLEASE CHECK THE BOX BELOW NOTING YOUR PREFERRED METHOD AND CONTACT DETAILS.**

Email Address: _____

FAX Number: _____

Requested Referral (please use separate forms for multiple referrals)

PCP Decision Support: Request a phone call (curbside consult) with a Beacon psychiatrist for member diagnostic or prescribing support. ****Include** med list and 2 PCP progress notes for psychiatrist review before phone call.

- Please note preferred date/time for consult: _____ (date) _____ (time)
- Best phone number to directly call PCP: _____

Fax form to: **866.422.3413** OR secure email: medi-cal.referral@beaconhealthoptions.com

Outpatient Behavioral Health Services: Refer members interested in therapy or medication management via Beacon's network when needs are outside PCP scope. Beacon coordinates with county mental health.

Fax form to: **866.422.3413** OR secure email: medi-cal.referral@beaconhealthoptions.com

Referral for Local Care Management: Local behavioral health care coordination services to help link members to mental health providers, support their transition between levels of care, or engage members with history of non-compliance and link them to community support services.

** For exchange of information include signed member Consent to Release Information.

Fax: **855-371-2279** OR email: MediCal_PHP@beaconhealthoptions.com

Request Reason (check all that apply):

Symptoms:

- | | |
|---|---|
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Abuse/CPS |
| <input type="checkbox"/> Poor self-care due to mental health | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> Psychosis (auditory/visual hallucinations, delusional) | <input type="checkbox"/> Homicidal Ideation |
| <input type="checkbox"/> PTSD/Trauma | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Violence/Aggressive Behavior | |
| <input type="checkbox"/> Substance use type: _____ | |
| <input type="checkbox"/> Other BH symptoms: _____ | |

Impairments:

- | | |
|--|---|
| <input type="checkbox"/> Difficult/Unable to complete ADLs | <input type="checkbox"/> Difficulties maintaining relationships |
| <input type="checkbox"/> Difficult/Unable to go to work/school | <input type="checkbox"/> Legal/CPS |
| <input type="checkbox"/> Other: _____ | |

Medications (list below or send medication list with this form):

