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:

☐Depression/Anxiety
☐Poor self-care due to mental health
☐Psychosis (auditory/visual hallucinations, delusional)
☐PTSD/Trauma
☐Violence/Aggressive Behavior
☐Substance use type: _____
☐Other BH symptoms: _____
☐Abuse/CPS
☐Suicidal Ideation
☐Homicidal Ideation
☐Chronic Pain
☐Perinatal Depression and/or Anxiety

Impairments:

☐Difficult/Unable to complete ADLs
☐Difficult/Unable to go to work/school
☐Other: _____
☐Difficulties maintaining relationships
☐Legal/CPS

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

_____

_____