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

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

Referring Provider: _____Name of Clinic/agency_____

Member Name:_____ Medi-Cal CIN #:_____ DOB: _____

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

Best day/times to reach Member: _____ _____(cell)

☐ **Please check** to confirm member eligibility was verified

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:* ***877.321.1787*** *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: ***8****77.321.1787 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 noncompliance and link them to community support services.
Fax: ***855-371-2279*** *OR email: MediCal_PHP@beaconhealthoptions.com*

Request Reason (check all that apply): *Symptoms:*

☐Depression	☐ Perinatal depression/anxiety	☐ PTSD/Trauma
☐Poor self-care due to mental health	☐ Abuse/CPS	☐ Violence/Aggressive bx
☐Psychosis (auditory/visual hallucinations, delusional)	☐ Psychological testing	☐ Chronic Pain
	☐ Neuropsychological testing	☐ Anxiety

☐ Adverse Childhood experiences (ACEs)

☐Substance use type: _____

☐Other BH symptoms: _____

Impairments:

☐Difficult/Unable to complete ADLs ☐Difficulties maintaining relationships ☐Legal/CPS

☐Difficult/Unable to go to work/school ☐Other:_____

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

_____

Motivation for Services (check all that apply)

☐ Member (or guardian) has been informed or referral to Beacon Health Options

☐ Member wants services for self (or dependent)

☐ If applicable, Patient has completed a PHQ-2/PHQ-9, Score _____