BEHAVIORAL HEALTH
REQUEST FOR SECOND OPINION

Date _____

Your Name _____Phone # _____
Please print

Name of person filling this form, if not the client _____

Relationship to client: _____

Client Address: _____
Street Address

_____
City, State, Zip Code

I request a review of the following (please check one and specify)

□ Diagnosis _____

□ Services _____

which have been decided by Humboldt County Behavioral Health.

I understand that Humboldt County Behavioral Health will provide for a Second Opinion from a qualified care professional within the Mental Health Plan (MHP) network, or will arrange to obtain a second opinion outside the MHP network if no qualified care professional within the MHP is available, at no cost to me.

Signature: _____Phone #_____

Give this completed request to the receptionist, or mail to:

Quality Improvement Coordinator
Humboldt County DHHS Behavioral Health
720 Wood St.
Eureka, CA 95501

We encourage you to discuss issues regarding your mental health services directly with your service providers or with their supervisors.

You may also contact the following people for help in resolving problems:

Quality Improvement Coordinator
707-268-2955, option #2
or
Toll Free 1-888-849-5728

Patients' Rights Advocate
707-268-2995

FOR QUALITY IMPROVEMENT DIVISION USE ONLY

Date received by Quality Improvement Division _____

Due date for Second Opinion assessment _____

Date forwarded: _____To: _____

****

MANAGER OR DESIGNEE, WHO RECEIVE THIS REQUEST FROM QI, PLEASE COMPLETE SECTION BELOW:

Decision:
Appointment scheduled for _____ with _____
Date Please print name and indicate title

□ Agree with the initial decision (please indicate reason and attach a copy of second opinion provider's documentation):
_____

_____

□ Revised decision from the original (please indicate reason and attach a copy of 2nd opinion provider's documentation):
_____

_____

Signature of Manager or Designee _____
Date _____

Return completed and signed form to Quality Improvement Department within two business days. Assigned clinical staff may need to authorize the change in services if necessary.

****

Date Quality Improvement Department was notified _____

Date written notification was sent to client by Quality Improvement
_____
(Please attach copy of letter if one was sent)

Signature of the Quality Improvement Coordinator or Designee
_____Date: _____