BEHAVIORAL HEALTH REQUEST FOR CHANGE OF SERVICE PROVIDER

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 change in my current service provider ______________________________
Please print name

for the following reasons: ____

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(Optional) I request a change to this provider: ___________________________________
Please print name

Check one:

- ☐ I have discussed my concerns with my current provider
- ☐ I have not discussed my concerns with my provider

Signature: ___________________________________ Phone #: ______________

Mail form to: Humboldt County Behavioral Health
Quality Improvement Coordinator
720 Wood St.
Eureka, CA 95501
707-268-2955

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

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FOR INTERNAL USE ONLY

Date received by Quality Improvement: ______________**Due Date**: ________________

Date forwarded: ________________To: ____

Decision

☐ Approved – New Provider:

____

Please print name

☐ Denied:

____

Reason

Date client notified: _________________ Date Provider(s) notified: __________________

Signature of Manager or Designee: ___________________________Date: ____________