REQUEST FOR CHANGE OF PROVIDER

CONTRA COSTA
MENTAL HEALTH
CARE MANAGEMENT SERVICES
1340 Arnold Dr., Suite 200
Martinez, California
94553-4634
Ph 925/957-5134
Fax 925/957-5156

OFFICE USE ONLY

Request No. ________________

Date Received________________

If you have been unable to resolve a problem with your service provider by speaking directly to them or the supervisor of the program where you are receiving care, then you may request a change of a service provider by completing this form and giving it to the receptionist. The program supervisor will review your request and will notify you of his/her decision within ten (10) working days. If you are a Medi-Cal beneficiary seeing a private provider in the community who is not part of a county operated clinic, call the Mental Health Access Line at 1-888 678-7277. Submitting a request does not guarantee that they will change your provider. If you disagree with the decision, you may file a formal grievance.

DATE ________________

TO: PROVIDER/PROGRAM SUPERVISOR

FROM:

____
(Client Name)

____
(Parent of Guardian if request is by or for a child or youth)

I request a change in my Current Provider

____
(Please print name of current provider)

for the following reasons: (add additional pages as needed)

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Check One

- ☐ I have discussed my concerns with this provider.
- ☐ I have **NOT** discussed my concerns with this provider.

I understand serious consideration will be given to this request and that I can expect a response within ten (10) working days.

Respond to me by phone: ______________________________
(Area Code and Telephone number)

or by mail: ______________________________
(Street Address)

____
(City, State, Zip Code)