Beacon Health Strategies
Primary Care Provider (PCP) Referral Form

Date: _____ **PCP Name**: _____ **Phone #**: _____

Member Name: _____ **Member ID #:** _____ **DOB:** _____

Language: _____ **Phone #'s:** _____ ; _____

PCP Request (one request per referral form)

☐**PCP Decision Support: Request a telephone consultation** with a Beacon psychiatrist to provide decision support related to member diagnostic and medication clarification or other clinical decision supports.
Include medication list and last 2 PCP Progress Notes for Psychiatrist review before phone consult with PCP. *Fax:* ***877.321.1787* *OR secure email: medi-calreferral@beaconhs.com*

☐**Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via Beacon's network of providers when their needs are outside the PCP scope of practice. Beacon can coordinate member care with county mental health.
** For exchange of information *back to the PCP*, include signed member Consent to Release of Information. *Fax:* ***877.321.1787*** *OR secure email: medi-calreferral@beaconhs.com*

☐**Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services:** Specialty services for youth under 21 years old with established diagnosis of Autism Spectrum Disorder (ASD).
**Include Progress Note with diagnosis of ASD and physician order requesting ABA services.
Fax to: ***800.596.2712***

☐**Referral for 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 *back to the PCP*, include signed member Consent to Release of Information. *Fax: 855-371-8113 OR email: MC_SFHP@Beaconhs.com*

Request Reason (check all that apply):

☐Depression ☐Anxiety ☐Other BH Diagnosis: _____
☐Isolation ☐Perinatal depression and/or anxiety ☐Auditory/Visual hallucinations
☐Trauma ☐Cognitively Impaired (or cognitive impairment) ☐Poor self-care due to mental health
☐Violence/Abuse ☐Substance use type: _____

☐Other BH symptoms: _____

Medical Diagnosis: _____

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

_____

_____

Other known barriers to member adherence to medical care: _____

Motivation for Services (check all that apply):
☐Member (or guardian) has been informed of referral to Beacon Health Strategies
☐Member wants services for self (or dependent)
☐If applicable, Patient has completed a PHQ-2/PHQ-9. Score _____

Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

Member Consent to Release Confidential Information

I, _____ give permission to _____
(Member Name) (Behavioral Health Provider)
and my Primary Care Physician _____ to share information about my
(Primary Care Physician)
diagnosis and / or treatment related to substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care.

This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.

_____ _____
Member/Guardian/Authorized Representative Date

_____ _____
Witness Date

Member Refusal to Release Confidential Information

I, _____ **DO NOT** give permission to _____
(Member Name) (Behavioral Health Provider)
and my Primary Care Physician _____ to share information about my
(Primary Care Physician)
diagnosis and / or treatment related to substance abuse, mental health, or medical history, including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage.

_____ _____
Member/Guardian/Authorized Representative Date

_____ _____
Witness Date

This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.