Beacon Health Options
Primary Care Provider (PCP) Referral Form

Date: _____ **PCP Name**: _____ **Phone #**: _____
Member Name: _____ **Member ID #:** _____ **DOB:** _____
Language: _____ **Member phone:** _____ **(home)**
Best days/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:** _____

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@beaconhealthoptions.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.
*Fax: **877.321.1787** OR secure email: medi-calreferral@beaconhealthoptions.com*

☐**Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services:** Specialty services for youth under 21 years old.
Please check one of the following boxes.
☐ I am submitting a Diagnostic Evaluation Form (attached) indicating diagnosis, problem behaviors and recommendation for BHT/ABA.
☐ I am recommending a referral for Diagnostic Evaluation for possible ABA recommendations.
*Fax form to: **877.321.1776 OR** secure email: care.managers@beaconhealthoptions.com*

☐**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 noncompliance and link them to community support services.

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 _____

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

BEACON

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.