Behavioral Health Services (BHS)
Authority and Quality Improvement Services (AQIS)

Orange County Mental Health Plan

Continuity of Care

How do I know if this information applies to me?

If you have Orange County Medi-Cal and are receiving ongoing Specialty Mental Health Services (SMHS) from a non-Medi-Cal or out-of-county network provider, or if you received SMHS from an out-of-network or terminated provider within the past 12 months, you may request to continue services with your pre-existing or current provider.

Can I keep the provider I have now?

If your provider agrees to work with the County of Orange Mental Health Plan (MHP) and the request meets all additional requirements for continuity of care, then you may be able to keep your pre-existing or current provider for up to 12 months. To "work with the Orange MHP" means that your provider must enter into an agreement with the Orange MHP so that your provider gets compensation from the Orange MHP. If your provider will not work with the Orange MHP, we will assist you in finding a new provider.

Ways to request Continuity of Care:

By Mail:

Send the Continuity of Care Request form to:
Health Care Agency
Authority & Quality Improvement Services
405 West 5th Street, Suite 410
Santa Ana, CA 92701

By Verbal Request:

Speak to the Provider Representative, the Service Chief, or the Program Director at this location

By Phone:

Authority & Quality Improvement Services
Main Line - (866) 308-3074
TDD only - (866) 308-3073

Please note: *You may make a direct request to the Mental Health Plan for continuity of care verbally, in writing or via telephone. Beneficiaries are not required to submit an electronic or written request*

Behavioral Health Services (BHS)
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Continuity of Care Request Form

To make a request without completing and submitting a form, you may ask to speak with the Provider Representative, the Service Chief or Program Director at this location or you can call Authority & Quality Improvement Services (AQIS) at (866) 308-3074 or (866) 308-3073 TDD.

Date of Request: _____ Medi-Cal Insurance: ☐ Yes ☐ No

Medi-Cal Beneficiary Information:

Name: _____ DOB: _____

Street Address: _____ Phone: _____

City, State, Zip: _____

Beneficiary has seen this provider at least once during the past 12 months prior to their initial enrollment in the MHP:	☐ Yes	☐ No
Beneficiary has evidence of treatment within the past 12 months (treatment records, letter from provider, etc.):	☐ Yes	☐ No
Beneficiary has completed an Authorization to Disclose Protected Health Information (attach, if completed) to verify treatment history with this provider:	☐ Yes	☐ No
Beneficiary feels the absence of continued services with this provider may result in detriment to their overall health and wellbeing:	☐ Yes	☐ No

Provider Information: [information of the individual with whom continued services are desired]

Name: _____ Phone: _____

Street Address: _____

City, State, Zip: _____

Form Completed By:

☐ Myself, the beneficiary

☐ Other, not the beneficiary

Relationship to beneficiary: _____

Name: _____

Phone: _____

Additional Information: [if applicable]

Mail Form To:

Health Care Agency - Authority & Quality Improvement Services
405 West 5th Street, Suite 410, Santa Ana, CA 92701