|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| The Following Process Must Be Followed To Ensure Client Privacy  * Complete appropriate fields and check boxes below (Click on or Tab between fields) * Send as attachment to AQIS Managed Care ([AQISManagedCare@ochca.com](mailto:AQISManagedCare@ochca.com)) * Send by itself with no other attachments * Subject Line: Change of Provider | | | HEALTH CARE AGENCYADULT & OLDER ADULT BEHAVIORAL HEALTHCOUNTY CLINICREQUEST FOR CHANGE OF PROVIDER/SECOND OPINION LOGFISCAL YEAR :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| QUARTER: (Check one) | JULY - SEPTEMBER | OCTOBER - DECEMBER | | JANUARY - MARCH | APRIL – JUNE |
|  | Submit by October 10 | Submit by January 10 | | Submit by April 10 | Submit by July 10 |

|  |  |
| --- | --- |
| Clinic & Program: |  |

**No Requests This Quarter**  
 (Example: Santa Ana Clinic - PACT)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Request** | **Medi-Cal** | **Reason** | **Client’s Name &**  **MRN #** | **Previous Provider** | **New provider** | **Reason for Request** | **Outcome of Request** | **Was a grievance filed? (Yes or No)  If NO, why?** |
|  |  | Provider change  2nd Opinion |  |  |  |  |  |  |
|  |  | Provider change  2nd Opinion |  |  |  |  |  |  |
|  |  | Provider change  2nd Opinion |  |  |  |  |  |  |
|  |  | Provider change  2nd Opinion |  |  |  |  |  |  |
|  |  | Provider change  2nd Opinion |  |  |  |  |  |  |
|  |  | Provider change  2nd Opinion |  |  |  |  |  |  |

**Service Chief Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**