|  |  |
| --- | --- |
| 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)
* 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:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**