



SIMON # _____
For Office Use Only

CHANGE OF PROVIDER REQUEST FORM - SIDE 1

As a consumer of Department of Behavioral Health, you have the right to request a change if you are not satisfied with your current service provider. Requesting a change of provider does not put you at risk of being denied behavioral health services or having the type of services you received changed.

If you would like to request a change of provider, please fill out this form as best you can in your own words. You can get help with filling out this form from the clinics supervisor at the location where you are receiving services, from the ACCESS Unit at (888) 743-1478, or from the Patients' Rights Office at (800) 421-4657.

Once you have filled out this form, please turn it into the receptionist at the clinic where you are currently receiving services.

Date Requested: _____
Client Name: _____ Date of Birth: _____
Phone Number: _____ SSN: XXX-XX _____

1. What is the name of the provider you would like to have changed?

2. Why are you asking for a change in provider?

3. What type of change do you want? _____

4. Did you talk to your current provider about your request for a change?
Yes If yes, please complete #5 If, No you are done.

5. What did your current provider say?

Thank you for completing this form.



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CHANGE OF PROVIDER REQUEST FORM - SIDE 2

THIS SIDE IS FOR STAFF USE ONLY

Name of Outpatient Clinic: _____

Clinic Response to Client Request: _____

Approvals:

Signature _____
Clinic Supervisor Date

Signature _____
Clinic Medical Director Date

NOTE: This form should be sent to the **ACCESS UNIT**, 303 E. VANDERBILT AVE., San Bernardino, CA 92415-0026 by the **5th** day of the month following that in which the change was requested.