Carelon Behavioral Health / L.A. Care Health Plan
Primary Care Provider (PCP) Referral Form

Referral Date:_____ Member Name:_____ Medi-Cal CIN ID#:_____

DOB: _____ Parent/Guardian Name:_____ Preferred Language: _____

Phone: _____ (home); _____ (parent/guardian's cell); _____ (member's cell)

Member address: _____

Does the minor 12 and older have capacity to give consent to services? ☐ Yes ☐ No If no, please explain _____

Best day/time to reach the member: _____ Best day and time to reach the parent/guardian: _____

PCP Clinic/Agency: _____ Name of PCP: _____ PCP Phone #: _____

To receive a confirmation of this referral's outcome, please check the box below noting preferred method and contact details:

☐ Email address: _____ ☐ Fax Number: _____

☐ **Please check** to confirm member eligibility was verified

PCP Request (one request per referral form)

PCP Decision Support: To obtain a mental health educational conversation with a Carelon Behavioral Health psychiatrist related to psychiatric diagnoses/medications. Contact the National Peer Advisor line: **Office Hours:** 6am-5pm PST Monday – Friday
Please call phone number: 877-241-5575

☐**Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via Carelon Behavioral Health's network of providers when their needs are outside the PCP scope of practice. Carelon Behavioral Health can coordinate member care with county mental health. *Fax:* ***877.321.1787*** *OR secure email:* medi-cal.referral@carelon.com

Request Reason (check all that apply):

Symptoms:

☐Depression
☐Poor self-care due to mental health
☐Psychosis (auditory/visual hallucinations, delusions)
☐ Adverse Childhood experiences (ACEs)
☐ Perinatal depression/anxiety
☐ Violence/Aggressive behavior
☐ Psychological testing
☐ Neuropsychological testing
☐ PTSD/Trauma
☐ Chronic Pain
☐ Anxiety
☐Substance use, please specify: _____
☐Other BH symptoms: _____

Impairments:

☐Difficulties/Unable to complete ADLs ☐Difficulties maintaining relationships ☐ Legal ☐ CPS
☐Difficulties/Unable to go to work/school ☐Other:_____

Medications (list below or send medication list with this form, please include dosage):

_____
_____

Motivation for Services (check all that apply)

☐ Member (or guardian) has been informed of referral to Carelon Behavioral Health
☐ Member wants services for self (or dependent)
☐ Member is unsure or ambivalent about services for self (or dependent)
☐ If applicable, Member has completed a PHQ-2/PHQ-9, Score _____

For members 12 and older, in certain situations under privacy law AB1184 a written ROI may be required to share sensitive information with anyone including parents and guardians. If possible, please send this referral form along with a completed release of information for anyone who may be involved in the member's care.

Authorization for Carelon Behavioral Health to Release Confidential Information

Important: By completing all sections of this form you allow Carelon Behavioral Health, Inc. to disclose health care information to the individuals you identify for up to one year. You may allow Carelon Behavioral Health to share health care information with your family, providers, legal representative, or **anyone** that you wish to have access. Please fill in all sections as incomplete forms may be returned.

Please note: It is also important for your doctor to have access to your medical information to ensure you receive the best care possible, including any follow-up medical care that may be needed. To allow Carelon Behavioral Health the ability to send your health care information to your doctor, complete and sign this form. We will only send information that pertains to your care.

If your request involves alcohol or substance use information, please pay attention to the special instructions in the applicable sections.

SECTION 1: WHOSE HEALTH CARE INFORMATION IS TO BE RELEASED?

I, _____**(Member Name)** authorize Carelon Behavioral Health, Inc. (or any Carelon Behavioral Health subsidiary holding my information) to disclose my health care information as described below.

Additional Member Identifying Information Member ID#: _____ DOB: ____/____/____

Phone Number: _____ Name of Health Plan: _____

SECTION 2: WHO IS TO RECEIVE THIS HEALTH CARE INFORMATION?

Print the Name(s) of person, provider or entity who will be receiving your information and contact information (if known):

_____

_____

_____

Phone Number of who will be receiving your information: _____

Is it ok to include information from past, present, and/or future treating provider(s)?: ☐ Yes ☐ No

SECTION 3: WHY SHOULD THIS HEALTH CARE INFORMATION BE RELEASED?

Reason: ("At my request" is an acceptable response):

_____

Specify, if possible:

☐Care Coordination/Management ☐Claim Assistance ☐Quality of Care Review

☐Other (Please explain reason): _____

SECTION 4: WHAT HEALTH CARE INFORMATION MAY BE RELEASED?

BY INITIALING the following items, you are authorizing Carelon Behavioral Health to release specific types of information to the party identified in Section 2 above:

_____Mental health information and/or records **(INITIALS REQUIRED)**

_____Alcohol or substance use information and/or records **(INITIALS REQUIRED)**

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_____ HIV/AIDS related information and/or records **(INITIALS REQUIRED)**

_____ Other health information, please specify **(INITIALS REQUIRED)**: _____

Special instructions, if any (you may specify provider, date span, service type, etc.): _____

_____

Optional: ☐ Claims info ☐ Authorizations ☐ Explanation of benefit letters ☐ Denials/Appeals info ☐ Clinical notes

SECTION 5: HOW LONG SHOULD THIS AUTHORIZATION LAST?

This authorization shall be in force and effect **for one year** or until I revoke it, in the manner described below or until **(insert expiration date or event)** _____ *(whichever is shorter)*.

SECTION 6: WHAT ARE MY RIGHTS?:

- You have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits.
- The information disclosed by this authorization may be at risk for re-disclosure by the recipient and if that happens, it might no longer be protected by federal privacy laws.
- You have a right to revoke this authorization at any time. ***But if you revoke this authorization, the revocation will not affect the disclosure of any information that Carelon Behavioral Health has already sent to the recipient***.
- If you authorized release of alcohol or substance use information to a healthcare organization that is not your treating provider, for the next two years, you have the right to find out who within that organization actually saw your information. You should contact the organization directly for that information.

Please note that if you have authorized the release of ONLY alcohol or substance abuse treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be in writing.

_____ _____

Signature of the Member or the Member's Legally Authorized Representative* Date

_____

Print Name

**** NOTE: If you are signing as the individual's Legally Authorized Representative, attach a copy of the appropriate legal document(s) granting you the authority to do so. Examples would be a health care power of attorney, a court order, guardianship papers, etc. A financial or business power of attorney is NOT sufficient.***

Please contact the phone number for behavioral health, mental health, or substance use services on your medical ID card with any questions or to determine where to mail or fax your request.