INYO COUNTY HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION

REQUEST FOR CHANGE OF PROVIDER
Title 9, Chapter 11. Sections 1830.225 (a) (b)

Note: Requesting a change of provider within the agency or to another agency shall not adversely affect your services with Inyo County Behavioral Health Plan.

As per Title 9, chapter 11, section 1810.405(e) you are entitled to a free of cost second opinion from a qualified health care professional within or outside the County.

Please provide the following:

Date:_____ Service Location:_____

Name:_____ Date of Birth:_____

Name of Legal Guardian (if client is a minor):_____

Address:_____

Phone Number (best time to call):_____

Linguistic and Cultural Needs:_____

1. I am requesting a change in: ___Counselor/Case Manager ___Medical Staff ___Agency

2. Please describe the reason(s) for requesting a change:_____

_____

_____

_____

3. Have you discussed your concerns with your service provider?

___Yes Please describe what you have done to try to resolve the problem and include the results:

_____

_____

___No

I understand that I will be contacted about this request within thirty (30) calendar days.

Requested on Date:	**Staff Name From:**	**Assigned Staff To:**	**Authorized Date:**	**initials**