Carelon Behavioral Health / an rancisco 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*

☐ **Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services:** Specialty services for youth under 21 years old with established diagnosis of Autism Spectrum Disorder (ASD) or for whom BHT/ABA services are medially necessary. **Include documentation or progress note with physician order requesting ABA services.
Fax: ***877.321.1776*** *OR secure email* *ASGCare.Managers@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.

Revised: 8/25/23