STANISLAUS BEHAVIORAL HEALTH AND RECOVERY SERVICES
CHANGE OF PROVIDER REQUEST FORM
(For Medi-Cal beneficiaries only)

Date: ______________________________

TO: Program Coordinator/Manager

CC: Managed Care Services

I request a change from my current provider listed below.

____
Name

____
Title

We welcome your feedback/requests and your services will not be adversely affected. To the degree possible, requests will be honored regardless of the reason for requesting a change. However, to help better serve you and for quality purposes, please check all that apply (Comments are optional):

- ☐ Prefer Different Provider within the Same Program ______________________________
- ☐ Prefer Different Provider and Different Program ______________________________
- ☐ Concerns About Provider Services ______________________________
- ☐ Scheduling Conflict ______________________________
- ☐ Location of Services ______________________________
- ☐ Prefer Different Provider with Gender/Cultural Heritage/Language Fluency ______________________________
- ☐ Other Reasons ______________________________

I ☐ have ☐ have not *(check one)* chosen to discuss my concerns with my current provider.

I understand that a response to this request can be expected in ten (10) working days and that I will be given instructions and/or contacted by my new provider regarding an appointment.

Sincerely,

______________________________ ______________________________
Client Signature Date of Birth

____
Client Name (Please Print)

____
Street Address

______________________________ ______________________________
City Zip Code Telephone Number