



BEACON HEALTH OPTIONS/GOLD COAST HEALTH PLAN PRIMARY CARE PROVIDER REFERRAL FORM

Referral Date: _____ PCP Name: _____ PCP Phone #: _____

Referring Provider: _____

Member Name: _____ Member ID#: _____ DOB: _____

Member's Preferred Language: _____ Member Phone #: _____ (home)

Please check to confirm member eligibility was verified: _____ (cell)

TO RECEIVE A CONFIRMATION OF THIS REFERRAL'S OUTCOME,
PLEASE CHECK THE BOX BELOW NOTING YOUR PREFERRED METHOD AND CONTACT DETAILS.

REQUESTED REFERRAL (please use separate forms for multiple referrals)

PCP Decision Support: Request a phone call (curbside consult) with a Beacon psychiatrist for member diagnostic or prescribing support.

** **Include** med list and 2 PCP progress notes for psychiatrist review **before** phone call.

• Please note preferred date/time for consult: _____ (date) _____ (time)

• Best phone number to **directly** call PCP: _____

Fax form to: **866-422-3413** OR secure email: medi-cal.referral@beaconhealthoptions.com

Outpatient Behavioral Health Services: Refer members interested in therapy or medication management via Beacon's network when needs are outside PCP scope. Beacon coordinates with county mental health.

Fax form to: **866-422-3413** OR secure email: medi-cal.referral@beaconhealthoptions.com

Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services: Specialty services for youth under age 21 with diagnosis of Autism Spectrum Disorder (ASD). ** **Include** progress note with ASD Dx and physician order requesting ABA services.

If there is a suspected but not yet established ASD diagnosis, please check one or both of the following boxes.

I am submitting a Diagnostic Evaluation Form (attached) indicating ASD red flags.

I am recommending a referral for Comprehensive Diagnostic Evaluation (CDE)

Fax form to: **800-596-2712** OR secure email: medi-cal.referral@beaconhealthoptions.com

REQUEST REASON (check all that apply):

Symptoms:

- | | |
|---|---|
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Abuse/CPS |
| <input type="checkbox"/> Poor self-care due to mental health | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> Psychosis (auditory/visual hallucinations, delusional) | <input type="checkbox"/> Homicidal Ideation |
| <input type="checkbox"/> PTSD/Trauma | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Violence/Aggressive Behavior | |
| <input type="checkbox"/> Substance use type: _____ | |
| <input type="checkbox"/> Other BH symptoms: _____ | |

Impairments:

- | | |
|--|---|
| <input type="checkbox"/> Difficult/Unable to complete ADLs | <input type="checkbox"/> Difficulties maintaining relationships |
| <input type="checkbox"/> Difficult/Unable to go to work/school | <input type="checkbox"/> Legal/CPS |
| <input type="checkbox"/> Other: _____ | |

Medications (list below or send medication list with this form): _____