Cal MediConnect Plan

PCP Referral Form for Behavioral Health Services

This form is for Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) members only.

Date:			
PCP information			
Name:		Phone:	
Member information			
Name:		Phone:	
Language:		DOB:	
ID number:			
☐ Please check to confirm member eligibility was verified.			

To receive a confirmation of this referral's outcome, please note your preferred method and contact details.

☐ Email address:	
☐ Fax:	

PCP request (one request per referral form)
☐ **PCP decision support:** Request a phone call (curbside consult) with a Beacon psychiatrist for member diagnostic or prescribing support. Include medication list and two PCP progress notes for psychiatrist review before phone call. Preferred date and time for consult: _____ (date) _____ (time) Best direct phone number for PCP:
Fax to: **1-866-422-3413** or secure mail to: **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 of the PCP's scope. Beacon coordinates with county mental health. Fax to: **1-877-450-5754** or secure mail to: **CMC_anthem@beaconhealthoptions.com**

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

https://mediproviders.anthem.com/ca

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Reason for the request: (Check all that apply.)

Symptoms:

- ☐ Depression/anxiety
- ☐ Poor self-care due to mental health
- ☐ Psychosis (auditory/visual hallucinations, delusional)
- ☐ PTSD/trauma
- ☐ Violence/aggressive behavior
- ☐ Abuse/Child Protective Services
- ☐ Suicidal ideation
- ☐ Homicidal ideation
- ☐ Chronic pain
- ☐ Substance abuse type: _____
- ☐ Other behavioral health symptoms: _____

Impairments:

- ☐ Difficulty/unable to complete activities of daily living
- ☐ Difficulty/unable to go to work/school
- ☐ Difficulties maintaining relationships
- ☐ Legal/Child Protective Services
- ☐ Other: _____

Medications: (List medications below or send a medication list with this form.)

For information and questions, please call **1-855-371-2283**.