

If you need assistance with completing this form:

- You may ask any Mental Health Plan staff to assist you.
 - You may call Member Services.
(916) 875-6069
- Toll Free 1-888-881-4 881
TTY (916) 876-8853
- You may call the Patient Rights Advocate.
(916) 333-3800

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**Sacramento County
Mental Health Plan**

**Request for
Change of
Provider**

Request Change of Provider – English

Sacramento County Mental Health Plan
Quality Management, Member Services
7001A East Parkway, Suite 300M
Sacramento, CA 95823

Sacramento County Mental Health Plan
Quality Management – Member Services
7001-A East Parkway, Suite 300M
Sacramento, CA 95823

Stamp
Required

Request for Change of Provider

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

Please print or write legibly.

Date: _____ Service Location: _____

Client Name: _____ Date of Birth: _____

If client is a minor, enter the name of
legal guardian filing on behalf of minor: _____

Address (City/State/Zip): _____

Phone Number (please indicate best time to call): _____

1. I am requesting a change in: Service Staff 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

Signature of person making this request: _____ Today's date: _____