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

Sacramento County MHP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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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

SACRAMENTO COUNTY

Sacramento County Mental Health Plan

Request for Change of Provider

Request Change of Provider – English

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: _____