



Beacon Health Strategies Primary Care Provider (PCP) Referral Form

Date: _____ PCP Name: _____ Phone #: _____

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

Language: _____ Phone #'s: _____ ; _____

PCP Request (one request per referral form)

PCP Decision Support: Request a telephone consultation with a Beacon psychiatrist to provide decision support related to member diagnostic and medication clarification or other clinical decision supports.
**Include medication list and last 2 PCP Progress Notes for Psychiatrist review before phone consult with PCP.
Fax: **866.422.3413** OR secure email: medi-calreferral@beaconhs.com

Referral for Outpatient Behavioral Health Services: Refer members for therapy or medication management via Beacon's network of providers when their needs are outside the PCP scope of practice. Beacon can coordinate member care with county mental health.
** For exchange of information back to the PCP, include signed member Consent to Release of Information.
Fax: **866.422.3413** OR secure email: medi-calreferral@beaconhs.com

Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services: Specialty services for youth under 21 years old with established diagnosis of Autism Spectrum Disorder (ASD).
**Include Progress Note with diagnosis of ASD and physician order requesting ABA services.
Fax to: **800.596.2712**

Referral for Care Management: Local behavioral health care coordination services to help link members to mental health providers, support their transition between levels of care, or engage members with history of non-compliance and link them to community support services.
** For exchange of information back to the PCP, include signed member Consent to Release of Information.
Fax: **877- 768-2306** OR email: cmc_aah@beaconhs.com

Request Reason (check all that apply):

- | | | |
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| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Poor self-care due to mental health |
| <input type="checkbox"/> Isolation | <input type="checkbox"/> Delusional | <input type="checkbox"/> Auditory/Visual hallucinations |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Violence/Abuse | <input type="checkbox"/> Cognitively Impaired (or cognitive impairment) |
| <input type="checkbox"/> Substance use type: _____ | | <input type="checkbox"/> Other BH Diagnosis: _____ |

Other BH symptoms: _____

Medical Diagnosis: _____

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

Other known barriers to member adherence to medical care: _____

Motivation for Services (check all that apply):

- Member (or guardian) has been informed of referral to Beacon Health Strategies
- Member wants services for self (or dependent)
- If applicable, Patient has completed a PHQ-2/PHQ-9. Score _____