



Beacon Health Options/Blue Shield of California Promise Health Plan
Primary Care Physician 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.

Email Address:

FAX Number:

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: 877.321.1787 OR secure email: PCPReferrals@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: 877.321.1787 OR secure email: PCPReferrals@beaconhealthoptions.com

Request Reason (check all that apply):

Symptoms:

- Depression/Anxiety, Poor self-care due to mental health, Psychosis (auditory/visual hallucinations, delusional), PTSD/Trauma, Violence/Aggressive Behavior, Substance use type, Other BH symptoms, Perinatal depression and/or anxiety, Abuse/CPS, Suicidal Ideation, Homicidal Ideation, Chronic Pain

Impairments:

- Difficult/Unable to complete ADLs, Difficult/Unable to go to work/school, Other, Difficulties maintaining relationships, Legal/CPS

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

Blank lines for listing medications