CONTRA COSTA HEALTH

Network Provider
Change of Treatment Authorization Request & Partnership Plan Update for Outpatient Services

Provider Last Name, First Name (and Group name, if applicable) | Beneficiary Last Name, First Name

Birth Date | **CIN #** (Medi-Cal Card #) | Medical Record # (**MRN**)

Please provide specifics of the change in frequency, quantity, duration, or modality that you are requesting.

Date that change is requested to start:	

*Must write full diagnosis narrative, no abbreviations

Current Primary DSM5 Medi-Cal Included Dx:		**DSM-5 Name***		**ICD-10**	F

Briefly provide the clinical justification for the request. Describe the current presenting problem, including details of any changes in client symptoms, functioning, and/or life circumstances since completion of the most recent Intake or Annual Update. Document any current safety risks, recent psychiatric hospitalizations, medication changes, and other resources available to support the client. Clients are expected to benefit from Medi-Cal Mental Health services, therefore, please document any reasons for client failure to make progress, or client regression. Describe how granting this request will help stabilize the client's current functioning, prevent hospitalization, incarceration, or a higher level of care.

Significant changes in the beneficiary's condition require updates to client Partnership Plans. If there is a safety risk, it must be addressed in the Partnership Plan. If an update to the treatment goals and/or strategies is needed, please complete the section below:
Updated Goal(s): **Updated Strategies:**

Provider Name: _____ Provider Signature: _____ Date: _____

Provider License/Designation: _____ License/Registration #: _____

Provider's Signature certifies that the above information is accurate and all required documentation is on file.

Beneficiary Signature: _____ Date: _____

☐ Unable to obtain signature prior to submission. Document reason in progress note. Date of Progress Note: