Change of Provider (clinician, case manager, doctor) Request Form

You may request a change of clinician, case manager, or doctor. While this is not always feasible, we will do our best to honor your request in a timely manner. To make such a request, please complete this form and give to the clinic receptionist, or you may return the form by mail to the:

Quality Improvement Unit

El Dorado County Mental Health Plan 768 Pleasant Valley Rd. Suite 200 Diamond Springs, CA 95619

Today's Date:	_
From:	
(Clien	nt's Name)
(Parent or Legal C	Guardian, if applicable)
The mental health provider I want to chang	ge is:
My reason for requesting the change (option	nal):
RESPOND TO ME BY PHONE:	
RESTORD TO ME DITHORE.	(Your Telephone Number)
OR BY MAIL:	
	(Street Address)
	(City, State, Zip Code)
Disposition: (to be completed by Program C	Coordinator, Manager, or QI Unit)
Name (please print)	Date:
[Send copy of this form to QI Unit when cor	