WE TRY TO do our best in working with both consumers and providers, but we understand that sometimes things do not work out as planned. If you are not satisfied with your mental health service provider and would like to change providers, please fill out this form. When you are finished, please mail it to:

Fresno County Mental Health Plan
P.O. Box 45003
Fresno, California 93718-9886

If you would like to speak with someone about this request, please call:
1-800-654-3937

For hearing impaired, dial **711** to reach the California Relay Service.

Thank you for taking the time to notify us.

Alternative formats available upon request.

FRESNO COUNTY
MENTAL HEALTH PLAN
1-800-654-3937

English
Change of Provider
07/2017

CHANGE OF PROVIDER

FRESNO COUNTY
MENTAL HEALTH PLAN
1-800-654-3937

IF YOU WOULD like to request a change of mental health provider, please fill out this form. When you are finished, please mail it to:

Fresno County Mental Health Plan
P.O. Box 45003
Fresno, California 93718

Forms and stamped, addressed envelopes are available at all mental health service sites.

You will receive a response within ten working days.

If you have any questions or want to speak with someone about your request, please call: 1-800-654-3937.

For hearing impaired, dial **711** to reach the California Relay Service.

CHANGE OF PROVIDER

Date:_____ Provider:_____

Name:_____
(if consumer is under 18 years old, please include name of parent or guardian)

I request a change of provider for the following reason(s):

_____

_____

_____

_____

Check one:
- ❒ I have discussed my concerns with my current provider.
- ❒ I have *not* discussed my concerns with my current provider.

Where can we contact you?_____

_____

_____

Primary Language Spoken:_____

Signed:_____