# Behavioral Health (BH) Care – Referral Request Form

The Alameda Alliance for Health (Alliance) Behavioral Health (BH) Care – Referral Request Form is confidential. Filling out this form will help us better serve our members. Please submit this form for routine referrals only (appointments within 10 business days). For expedited, urgent, or emergent behavioral health care services, DO NOT submit this form, please call toll-free at **1.855.856.0577** for immediate triage and referral.

**INSTRUCTIONS**

1. Please print clearly, or type in all of the fields below.
2. Please fax the completed form to the Alliance Behavioral Health Department at **1.855.891.9168** or send a secure email to **deptbhmentalhealth@alamedaalliance.org**.

For questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

**PLEASE NOTE:** If this referral is for autism evaluation, behavioral health treatment/applied behavioral analysis (BHT/ABA), please complete the attached Behavioral Health (BH) Care – Autism Evaluation, BHT/ABA Referral Form.

## SECTION 1: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Phone Number: _____

Alliance Member ID #: _____

Notes:

## SECTION 2: REQUESTING PROVIDER INFORMATION

Request Date (MM/DD/YYYY): _____ Organization Name: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Notes:

## SECTION 3: REFERRAL INFORMATION

Is the member aware of this referral request? ☐ Yes ☐ No

Is the member in agreement with this referral? ☐ Yes ☐ No

Message to the behavioral health care provider:

## SECTION 4: DIAGNOSIS

DSM Code: Description:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

## SECTION 5: REFERRAL INFORMATION

Service Requested: _____

Select the preferred referral for a behavioral health care provider (please select only one (1)):

☐ Refer to the first available behavioral health care provider

☐ Refer to a specific in-network Alliance behavioral health care provider

*Behavioral Health Care Provider Full Name:* _____

### Mental Health Evaluation/Services

Is the referral a patient request? ☐ Yes ☐ No

Has the member previously taken behavioral health medication? ☐ Yes ☐ No

Is the member currently taking behavioral health medication? ☐ Yes ☐ No

Is the member currently in psychotherapy (talk therapy)? ☐ Yes ☐ No

### Behavioral Health Care Treatment/Evaluation Services for Autism Spectrum Disorder (ASD)

Select the following services based on the member's needs (please select all that apply):

☐ Autism evaluation and/or BHT/ABA
*(If selected, please complete the attached BH Care – Autism Evaluation, BHT/ABA Referral Form)*

☐ Additional assessment services

☐ Speech assessment/therapy

☐ Other: _____

## SECTION 5: ADDITIONAL INFORMATION

Please provide any additional information you would like to communicate to the behavioral health care provider or Alliance care manager:

## SECTION 6: REFERRING PROVIDER SIGNATURE

Full Name (Print): _____

Signature: _____ Date: _____