BEHAVIORAL HEALTH
REQUEST FOR SECOND OPINION

Date ___________________

Your Name __________________________________Phone # ____________________

Please print

Name of person filling this form, if not the client ______________________________

Relationship to client: _____________________

Client Address: ____________________________________________________

____________________________________________________________________

City, State, Zip Code

I request a review of the following (please check one and specify)

☐ Diagnosis ______________________________________________________

☐ Services _______________________________________________________

which have been decided by Humboldt County Behavioral Health.

I understand that Humboldt County Behavioral Health will provide for a Second Opinion from a qualified care professional within the Mental Health Plan (MHP) network, or will arrange to obtain a second opinion outside the MHP network if no qualified care professional within the MHP is available, at no cost to me.

Signature: ________________________________Phone # ____________________

Give this completed request to the receptionist, or mail to:

Quality Improvement Coordinator
Humboldt County DHHS Behavioral Health
720 Wood St.
Eureka, CA 95501

We encourage you to discuss issues regarding your mental health services directly with your service providers or with their supervisors.

You may also contact the following people for help in resolving problems:

Quality Improvement Coordinator
707-268-2955, option #2
or
Toll Free 1-888-849-5728

Patients' Rights Advocate
707-268-2995

Rev 3/27/2020
FOR QUALITY IMPROVEMENT DIVISION USE ONLY

Date received by Quality Improvement Division ______________________________

Due date for Second Opinion assessment ________________________________

Date forwarded: _______________ To: ________________________________

**********************************************************************************************

MANAGER OR DESIGNEE, WHO RECEIVE THIS REQUEST FROM QI, PLEASE COMPLETE
SECTION BELOW:

Decision:
Appointment scheduled for ____________ with _______________________________

 Date  Please print name and indicate title

□ Agree with the initial decision (please indicate reason and attach a copy of
second opinion provider’s documentation):
_________________________________________________________________________________
_________________________________________________________________________________

□ Revised decision from the original (please indicate reason and attach a copy of
2nd opinion provider’s documentation):
_______________________________________________________________________________
_______________________________________________________________________________

Signature of Manager or Designee __________________________________________
Date __________________

Return completed and signed form to Quality Improvement Department within two business days.
Assigned clinical staff may need to authorize the change in services if necessary.

**********************************************************************************************

Date Quality Improvement Department was notified ______________________________

Date written notification was sent to client by Quality Improvement __________________

(Please attach copy of letter if one was sent)

Signature of the Quality Improvement Coordinator or Designee
_______________________________________________________________________________ Date: __________

Rev 3/27/2020