



## BENEFICIARY REQUEST FOR SECOND OPINION

As a Medi-Cal beneficiary you have the right to request a second opinion by a licensed mental health professional when you disagree with a decision or action of the Mental Health Plan.

Please fill out this form as best you can in your own words. You can obtain assistance with completing the form by contacting the Access Team at (1-888-868-1649). Please return the completed form to the Mental Health Plan Access Team. Upon receipt of this form an appointment for a second opinion will be scheduled within two weeks.

- 1) Why did you originally come to the Mental Health Plan for help?
  
- 2) What kind of help or specific services do you think you need?
  
- 3) Why are you requesting a second opinion?
  
- 4) How would you like to have the problem resolved, or what would you like done differently?
  
- 5) Did you receive a *Notice of Action* letter regarding this matter?       YES       NO

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ DOB \_\_\_\_\_

Please return this form to:	Santa Barbara County Department Behavioral Wellness
	Quality Assurance: 5385 Hollister Ave. Bldg. #14, Box 102
	Santa Barbara, CA 93111