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Alameda County Behavioral Health Care Services

REQUEST FOR PRIOR CONSULTATION

USE TO PROVIDE INFORMATION BEFORE CLIENT HAS BEEN SEEN AS REQUIRED IN SPECIAL CASES (E.G.: UNDER 18 YR., OVER 64 YR., PSYCHODIAGNOSTIC SERVICES) SUBMIT THIS INFORMATION DIRECTLY TO ACCESS PROGRAM WITH BENEFICIARY REGISTRATION FORM.

BENEFICIARY NAME: _____

BIRTHDATE: _____

SSN: _____

MEDI-CAL NUMBER: _____

Reason Prior Review Is Requested

- ☐ BENEFICIARY IS UNDER 18
- ☐ BENEFICIARY IS OVER 64
- ☐ PSYCHODIAGNOSTIC SERVICE IS PLANNED
- ☐ REQUESTING PRE-SERVICE REVIEW FOR MEDICAL NECESSITY

Special Programs Requiring Prior Review

SOCIAL SERVICES REFERRAL? **Y** ☐ **N** ☐

CALWORKS REFERRAL? **Y** ☐ **N** ☐

Referral Source/Agencies Involved in Referral

Presenting Problem

Symptoms/Impairments Requiring Service

Planned Intervention (must address symptoms and impairments listed above)

CLINICIAN NAME: _____ PHONE: _____ FAX: _____

PROVIDER NUMBER: _____ IF CLINIC, GIVE NAME: _____

PERSON COMPLETING FORM _____ (PRINT) SIGNATURE: _____ DATE: _____

ACCESS REVIEWER _____ STAFF # _____ DATE: _____

Revised 5-13-98

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