Lake County Behavioral Health

REQUEST FOR TRANSFER / CHANGE OF PROVIDER REQUEST FORM

Client Name____

Current Provider's Name ___________________________________

Services Provided ____

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Reasons for Change of Provider Request

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❑ Current Provider Notified of Request

❑ I prefer not to discuss this request with my current provider.

Client Signature ___________________________Date ___________

OFFICE USE ONLY

❑ Request Approved and New Provider Assigned

❑ Request Denied:

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LCBH Team Member Signature___________________________ Date ____________