

Healthy Louisiana Mental Health Rehabilitation Member Choice Form

Member name:

Member DOB:

Member ID:

Member information: I am requesting services from a mental health rehabilitation (MHR) provider. I understand that I have the right to choose an agency to provide services to me or my child. I understand that I may only receive MHR services from one provider unless my health plan makes an exception. I may change providers if I am not satisfied with the services.

If assistance is needed with finding an MHR provider, review the list of providers located at your health plan's website below or call your plan for assistance.

1. Aetna: www.aetnabetterhealth.com/louisiana/find-provider or call **1-855-242-0802 (TTY/TDD 711)**.
2. Amerihealth Caritas Louisiana: www.amerihealthcaritasla.com/member/eng/tools/find-provider.aspx or call **1-888-756-0004 (TTY 1-866-428-7588)**.
3. Healthy Blue: www.myhealthybluel.com/la/care/find-a-doctor.html or call **1-844-227-8350 (TTY/TTD 711)**.
4. Louisiana Healthcare Connections: <https://providersearch.louisianahealthconnect.com> or call **1-866-595-8133 (TTY/TTD 711)**.
5. United Healthcare Community: www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html or call **1-866-675-1607 (TTY 1-877-4285-4514)**.

The provider that I have freely selected to deliver MHR services to me, or my child is:

Provider name: The Gift Mental Health Clinic, LLC

Provider phone number: 504-644-2575

Provider contact name: Will Bell

Provider address: 3301 Canal Street #1 New Orleans, La 70119

By signing the form below, I understand that I have chosen to receive services from this MHR provider, and I acknowledge that it is my responsibility to notify my previous provider so they can coordinate my care with my new provider. I understand that I am free to choose any MHR provider in my health plan's network.

Member/legal guardian signature:

(Electronically signed)

Printed legal guardian name (if applicable):

Provider's information: A Member Choice form is required prior to receiving any mental health rehabilitation services. This form requires member/legal guardian signature, date, identified provider with telephone and contact name. The provider is responsible for coordinating the transition of care with the member's previous provider prior to starting services.

Provider signature: W. Bell (electronically signed)

Date:

