## Appendix 18b • Client's Physicians and Other Health Professionals (Optional)

Client's Last Name			First Name			MSSP #
NAME:	MSSP Assessment Date Last seen by HP?		1	2	3	4
SPECIALTY:						
ADDRESS:						
PHONE:	MSSP Assessment Date Last seen by HP?		5	6	7	8
MEDI-CAL PAYS?						
NAME:	MSSP Assessment Date Last seen by HP?		1	2	3	4
SPECIALTY:						
ADDRESS:						
PHONE:	MSSP Assessment		5	6	7	8
MEDI-CAL PAYS?	Date L					
□ Yes □ No	seen by HP?					
NAME:	MSSP Assess		1	2	3	4
SPECIALTY:	Date L	ast				
ADDRESS:	HP?	4				
PHONE:	MSSP Assess		5	6	7	8
MEDI-CAL PAYS?	Date L seen b	ast				

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