State of Maryland

REQUEST FOR REIMBURSEMENT FOR NON-MEDICAID OUTPATIENT SERVICES

(Form to be sent by CSA/LAA to Beacon Health Options if approved)

☐ **Case Management Services Approved (check only if this is Case Management)**

☐ **Hospital Diversion**

☐ **Uninsured Coverage – CSA/LAA Exception**

☐ **Uninsured Coverage – SUD Related Services**

FOR PROVIDER USE ONLY:			
Beacon Health Options (BHO) Provider Number:		Provider Name:	
Provider Contact Name:		Provider Phone Number:	
Provider Fax Number:		Provider Email Address:	
CONSUMER INFORMATION:			
Registration Date:		Consumer or Medicaid ID:	
Last Name:	First Name:	Middle Initial:	Suffix:
Gender:	☐ Female ☐ Male ☐ UNK		
Date of Birth:		SSN: ☐ No SSN ☐ Unknown SSN	
Primary Address:	Street:		
	City:		
	State:		
	Zip:		
	County		
	Phone:		

- Please be sure to complete both pages, if appropriate -

FOR PROVIDER USE FOR SUD RELATED SERVICES:	
Consumer Status:	☐ Already in Care ☐ New to Care
Financial Reason for Exception:	☐ Lacks all needed documentation for eligibility ☐ Non-US Citizen / Undocumented Income is: ☐ 250% - 400% of FPL ☐ 400% - 600% of FPL ☐ 600% - 800% of FPL ☐ over 800% of FPL ☐ Private Insurance doesn't cover services ☐ Has Private Insurance, but high co-pay / deductible ☐ Eligible for Health Insurance (HI) Exchange, didn't sign up ☐ Has HI Exchange, but high co-pay / deductible ☐ Has Medicare, can't get private insurance
Clinical Reason for Exception:	☐ Imminent potential harm to individual and/or public ☐ Receiving medication to treat opioid disorder ☐ Release from prison, jail, or DOC within the last three months ☐ Pregnant ☐ Has HIV/AIDS ☐ Discharged from psychiatric hospital in last three months ☐ Requesting services required by HG 8-507 ☐ Other (Provid detail below)

FOR CSA/LAA USE ONLY:	Eligibility Fax: 1.855.378.8310
	☐ **Approved** ☐ **Denied**
Reason for Exception or Denial:	
CSA/LAA Name:	
	CSA/LAA Email:
	CSA/LAA Phone Number:
	CSA/LAA Fax Number:
Comments:	

FOR BEACON HEALTH OPTIONS USE ONLY:	
Consumer ID:	
Comments:	