NEW PROVIDER & LOCATION/SERVICE CHANGE FORM

MARYLAND GAMBLING PROGRAM

Please be sure to select network status and program type. Complete the information below to include billing information, service location (s) and program type at location. Please indicate effective date of program type for each location, which determines the effective date of when the Gambling fees and codes will become activate. Providers will not be able to submit an authorization request with a start date prior to effective date of fees and codes for each location. Claims will deny for date of services submitted prior to effective date of fees and codes for each location as well. If changing program type at a location or closing a location, please indicate the effective date of change for that location. The applicable Gambling service fee schedule will expire for that location, and claims submitted for dates of service after expiration date will deny.

A "New Provider & Location/Service Change Form" is needed for any updates to provider file and for each location.

*__PROGRAM TYPE__ **(check all that apply)**

☐ GAMBLING PROVIDER
- ☐ MENTAL HEALTH PROVIDER
- ☐ SUBSTANCE USE PROVIDER
- ☐ RESIDENTIAL PROVIDER

*__NETWORK STATUS__

☐ NEW PROVIDER

☐ EXISTING PROVIDER BEACON SIX DIGIT PROVIDER # ___________________
- ☐ CHANGING PROGRAM TYPE AT LOCATION
- ☐ CLOSING LOCATION/SERVICE
- ☐ ADDING A LOCATION/SERVICE

PROVIDER CONTACT & SERVICE LOCATION

*CONTACT NAME: ______________________________ PHONE #: _______________________

EMAIL ADDRESS: __________________________________

***PROGRAM NAME**: ____

- ADDRESS: ____
- CITY: ______________________________________ STATE: _______ ZIP: _________________
- PHONE: ______________________________________ FAX: __________________________

If applicable current locations: NPI # ______________________ MEDICAID # ______________________

***EFFECTIVE DATE:** _______________________
Please select an effective date in which either the new location fee schedule will become active, or effective date fee schedule will expire at location

***PROVIDER BILLING INFORMATION** *(send payments to)*

NAME: ____

ADDRESS: ____

CITY: ______________________________________ STATE: _______ ZIP: ______________

TAX IDENTIFICATION #: _______________________ BILLING PROVIDER NPI # _______________________

Please fax completed forms to the Provider Relations team at 410.691.4001 or email MarylandProviderRealtions@BeaconHealthOptions.com

FOR BEACON USE ONLY

Approved by Beacon Health Options

*Print Name and Title: ____

*Signature: __________________________________ *Date: ______________________

Additional Comments:

Received by: __________________________ Date Received: ____________

Providers ID #: ____________