

State of Maryland

REQUEST FOR REIMBURSEMENT FOR NON-MEDICAID SERVICES (Form to be sent by CSA/LAA/LBHA to Beacon Health Options if approved for Exception to Required Uninsured Criteria)

Type of Service: Mental Health Substance Use Disorder

FOR PROVIDER USE ONLY:

Beacon Health Options Provider Number:

Provider Name:

Contact Name:

Provider Email Address:

Provider Phone Number:

Provider Fax Number:

Consumer Information:

Registration Date:

Consumer or Medicaid ID:

Last Name:

First Name:

MI:

Suffix:

Gender: Female Male

Unknown

Date of Birth:

SSN:

No SSN

Unknown SSN

Primary Address:

Street:

City:

State:

Zip Code:

County:

Phone:

Level of Care Requested:

MH Case Management

SUD Outpatient

MH Outpatient

SUD Methadone Maintenance

MH Mobile Treatment

SUD Intensive Outpatient

MH Psychiatric Rehabilitation

SUD Residential ASAM Level 3.3

MH Respite Care

SUD Residential ASAM Level 3.5

MH Supported Employment

SUD Residential ASAM Level 3.7

MH Residential Crisis

SUD Residential ASAM Level 3.7WM

Other

- 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 (check all that apply):

Lacks all needed documentation for eligibility

Private Insurance doesn't cover services

Non-US Citizen / Undocumented

Has Private Insurance, but high co-pay / deductible

Income is x% of Federal Poverty Level (FPL):

Eligible for Health Insurance Exchange, but didn't sign up

250% - 400% of FPL

Has Health Insurance Exchange, but high co-pay / deductible

400% - 600% of FPL

Has Medicare and can't get private insurance

600% - 800% of FPL

Over 800% of FPL

Clinical Reason for Exception (check all that apply):

Imminent potential harm to individual and/or public

Pregnant

Receiving medication to treat opioid disorder

Has HIV/AIDS

Discharged from psychiatric hospital in last 3 months

Requesting services required by HG 8-507

Release from prison, jail, or DOC within the last 3 months

Other Explain:

FOR CSA/LAA/LBHA USE ONLY:

Reimbursement Status:

Approved

Denied

Reason for Exception or Denial:

CSA/LAA/LBHA Name:

CSA/LAA/LBHA Email Address:

CSA/LAA/LBHA Phone Number:

CSA/LAA/LBHA Fax Number:

Additional Comments:

FOR BEACON HEALTH OPTIONS USE ONLY:

Consumer ID:

Comments: