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

MH Outpatient

MH Mobile Treatment

MH Psychiatric Rehabilitation

MH Respite Care

MH Supported Employment

MH Residential Crisis

Other

SUD Outpatient

SUD Methadone Maintenance

SUD Intensive Outpatient

SUD Residential ASAM Level 3.3

SUD Residential ASAM Level 3.5

SUD Residential ASAM Level 3.7

SUD Residential ASAM Level 3.7WM

- 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):
  - 250% - 400% of FPL
  - 400% - 600% of FPL
  - 600% - 800% of FPL
  - Over 800% of FPL
- Eligible for Health Insurance Exchange, but didn't sign up
- Has Health Insurance Exchange, but high co-pay / deductible
- Has Medicare and can't get private insurance

Clinical Reason for Exception (check all that apply):

- Imminent potential harm to individual and/or public
- Pregnant
- Receiving medication to treat opiod 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: