EMHS Employee Health Plan
POWERED BY BEACON HEALTH

Authorizations and Medical Management
Phone: 855-429-1024
Fax: 877-403-7162
Address: Beacon Health
PO Box 202316
Austin, TX 78720

Requestor's Contact Name:		Requestor's Contact #:	
Patient Information:			
*Name:		*DOB:	
*Member ID #:		*Member Phone #:	
Work Related Injury? ☐ Yes ☐ No		Motor Vehicle Accident related injury? ☐ Yes ☐ No	
Does the member have other insurance? ☐ Yes ☐ No		If Yes, other insurer	
Does the member have Medicare? ☐ Yes ☐ No		If Yes, ☐ Part A ☐ Part B	
*Service Is: ☐ Elective / Routine		☐ Expedited / Urgent	

Note: Selected Expedited/ Urgent to prevent serious deterioration in health or jeopardize ability to regain maximum function.

(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at 1-800-429-1023)

***Referral Service Type Requested:** Please review plans benefit prior to request

Inpatient	Outpatient	Behavioral Health	Other
☐ Emergent Inpatient	☐ Surgical Procedure	☐ Inpatient	☐ Home Health /Skilled Services
☐ Concurrent Review	☐ PT, OT, ST	☐ Partial Hospitalization	☐ (SN/PT/OT/SP)
☐ Surgical Procedures	☐ Imaging	☐ Intensive Outpatient (IOP)	☐ Private Duty Nursing
☐ Elective Admission	☐ Chiropractic	☐ Residential Treatment	☐ (see PDN specific form)
☐ Elective Observation	☐ Acupuncture	☐ Chemical Dependency	☐ DME
☐ SNF	☐ Hospice	☐ Office Visit	☐ Transportation / Transfers
☐ Rehab		☐ Other Therapy:	☐ Air Ambulance
☐ Maternity			☐ Other:
☐ NICU			
☐ Hospice			

Procedure Information:		
***ICD 10** Diagnosis:	Diagnosis Description:	
***CPT/HCPC** Code & Description *(Include Unit of Measure / Frequency for supplies):*		
*Date(s) of Service:	Number of Visits:	
Provider Information:		
Ordering Provider	Is this the member's Primary Care Physician?	☑ Yes ☐ No
*Name:	*NPI	TIN:
*Phone:	*Fax	
*Address:		
Servicing Provider	Is this the same as the Ordering Provider?	Yes No
If not complete below:		
*Name	*NPI	TIN:
*Phone	*Fax:	
*Address		
Facility		
*Name:	*NPI	TIN:
*Phone	*Fax	
*Address		

Request for extension to authorization request:

For SCA Coordination Needs

Name:_____ **Phone:**_____

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NEXESSITY. INCOMPLETE INFORMAITON MAY DELAY THE PROCESS.

Always verify eligibility, benefits and prior authorization requirements