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 Number: _____

Patient Information

*Name: _____ *DOB: _____

*Member ID Number: _____ *Member Phone Number: _____

***Service Is:** ☐ **Elective/Routine** ☐ **Expedited/Urgent**

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

(For Claim Denial or Prior Authorization Denial, please submit an Appeal through Customer Service at 877-403-7162

*Referral Service Type Requested			
Inpatient	**Outpatient**	**Behavioral Health**	**Other**
☐ Surgical Procedures	☐ Surgical Procedure	☐ Inpatient	☐ Skilled Service (SN/PT/OT/SP)
☐ Elective Admission	☐ PT,OT, ST	☐ Partial Hospitalization	☐ DME
☐ Elective Observation	☐ Imaging	☐ Intensive Outpatient (IOP)	☐ Dental
☐ SNF	☐ Chiropractic	☐ Chemical Dependency	☐ Experimental/Investigational
☐ Rehab	☐ Acupuncture	☐ Office Visits	☐ Transportation/Transfers
☐ LTAC	☐ Infusion Therapy		☐ _____

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: ☐ *Primary Care Physician*

*Name: _____ *NPI: _____ TIN: _____

*Phone _____ *Fax _____

*Address: _____

Servicing Provider: ☐ *Same as Ordering*

*Name: _____ *NPI: _____ TIN: _____

*Phone: _____ *Fax: _____

*Address: _____

Facility: ☐ *N/A*

Name: _____ *NPI: _____ TIN: _____

*Phone: _____ *Fax: _____

*Address: _____

Request for extension to authorization: _____

ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY. INCOMPLETE INFORMATION MAY DELAY THE PROCESS