Northern Light. Beacon Health Employee Health Plan

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	Private Duty Nursing
Elective Admission	Chiropractic	(IOP) Residential	(see PDN specific form)
Elective	Acupuncture	Treatment Chemical	DME
Observation SNF	Hospice	Dependency Office Visit	Transportation / Transfers
Rehab		Other Therapy:	Air Ambulance
Maternity			Other: Click here to enter text.
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	
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 NECESSITY. INCOMPLETE INFORMAITON MAY DELAY THE PROCESS.

Always verify eligibility, benefits and prior authorization requirements