

# State of Maryland

REQUEST FOR REIMBURSEMENT FOR NON-MEDICAID OUTPATIENT SERVICES  
(Form to be sent by CSA/LAA to Beacon Health Options if approved)

**Case Management Services Approved (check only if this is Case Management)**

**Hospital Diversion**

**Uninsured Coverage – CSA/LAA Exception**

**Uninsured Coverage – SUD Related Services**

<b>FOR PROVIDER USE ONLY:</b>			
Beacon Health Options (BHO) Provider Number:		Provider Name:	
Provider Contact Name:		Provider Phone Number:	
Provider Fax Number:		Provider Email Address:	
<b>CONSUMER INFORMATION:</b>			
Registration Date:		Consumer or Medicaid ID:	
Last Name:	First Name:	Middle Initial:	Suffix:
Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> UNK		
Date of Birth:	SSN:	<input type="checkbox"/> No SSN <input type="checkbox"/> Unknown SSN	
Primary Address:	Street:		
	City:		
	State:		
	Zip:		
	County		
	Phone:		

- 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:	Lacks all needed documentation for eligibility Non-US Citizen / Undocumented Income is: 250% - 400% of FPL 400% - 600% of FPL 600% - 800% of FPL over 800% of FPL	Private Insurance doesn't cover services Has Private Insurance, but high co-pay / deductible Eligible for Health Insurance (HI) Exchange, didn't sign up Has HI Exchange, but high co-pay / deductible Has Medicare, can't get private insurance
Clinical Reason for Exception:	Imminent potential harm to individual and/or public Receiving medication to treat opioid disorder Release from prison, jail, or DOC within the last three months Pregnant Has HIV/AIDS Discharged from psychiatric hospital in last three months Requesting services required by HG 8-507 Other (Provide detail below)	

FOR CSA/LAA USE ONLY:	Eligibility Fax: 1.855.378.8310
	<input type="checkbox"/> <b>Approved</b> <input type="checkbox"/> <b>Denied</b>
Reason for Exception or Denial:	
CSA/LAA Name:	
	CSA/LAA Email:
	CSA/LAA Phone Number:
	CSA/LAA Fax Number:
Comments:	

FOR BEACON HEALTH OPTIONS USE ONLY:
Consumer ID:
Comments: