

# 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

SUD Outpatient

MH Outpatient

SUD Methadone Maintenance

MH Mobile Treatment

SUD Intensive Outpatient

MH Psychiatric Rehabilitation

SUD Residential ASAM Level 3.3

MH Respite Care

SUD Residential ASAM Level 3.5

MH Supported Employment

SUD Residential ASAM Level 3.7

MH Residential Crisis

SUD Residential ASAM Level 3.7WM

Other

- 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 <u>x</u> % of Federal Poverty Level (FPL):	Eligible for Health Insurance Exchange, but didn't sign up	
250% - 400% of FPL	Has Health Insurance Exchange, but high co-pay / deductible	
400% - 600% of FPL	Has Medicare and can't get private insurance	
600% - 800% of FPL		
Over 800% of FPL		
Clinical Reason for Exception (check all that apply):		
Imminent potential harm to individual and/or public	Pregnant	
Receiving medication to treat opioid 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: