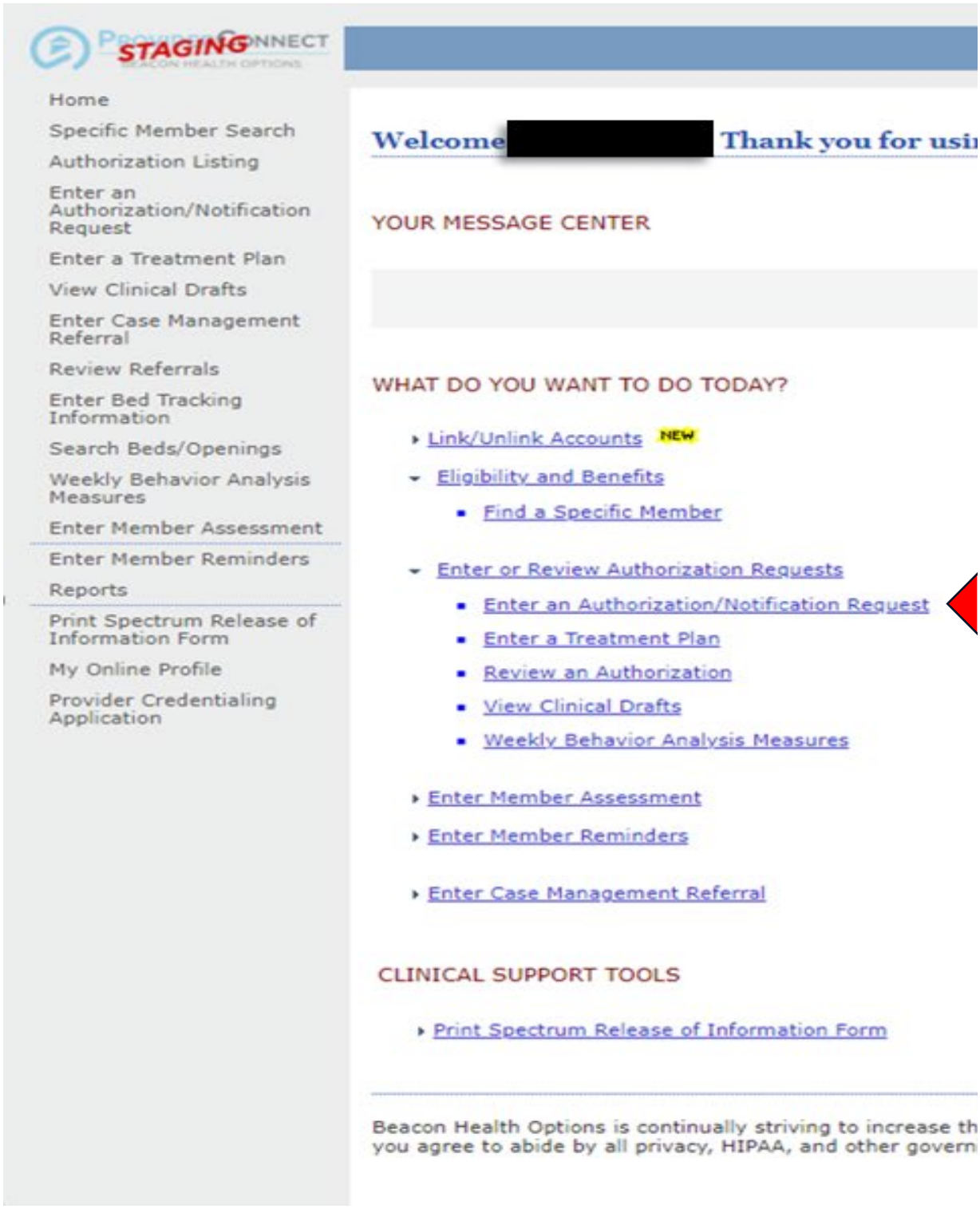
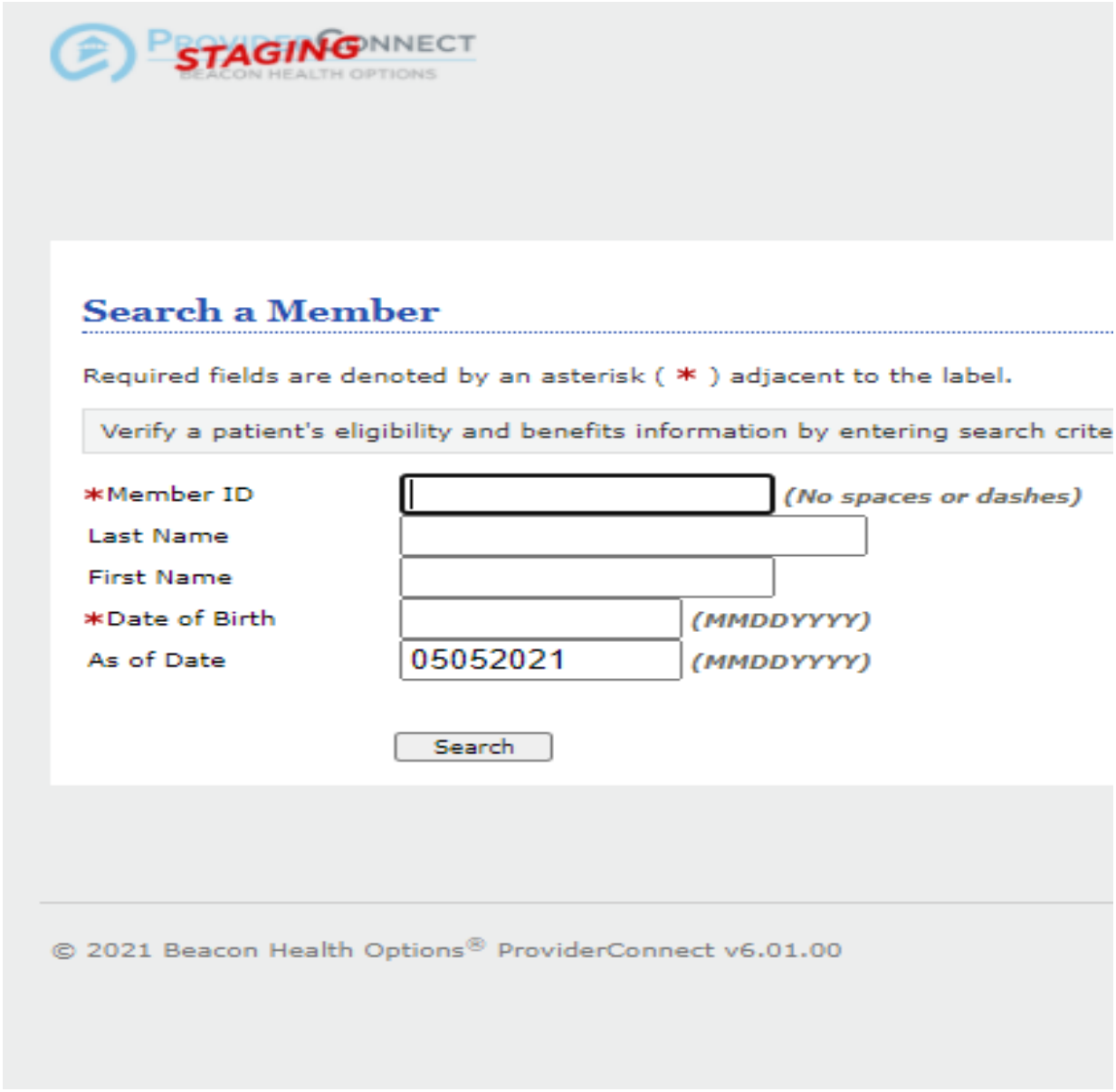
Provider Connect - Main Menu

From the Provider Connect Main Menu, select Enter an Authorization/Notification Request



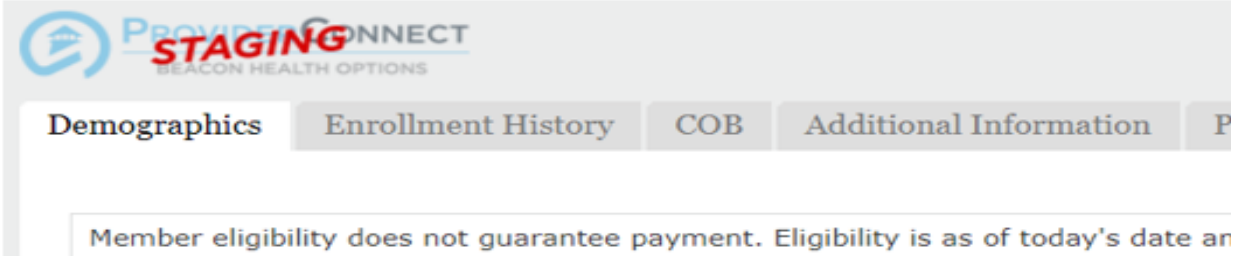
Member Search

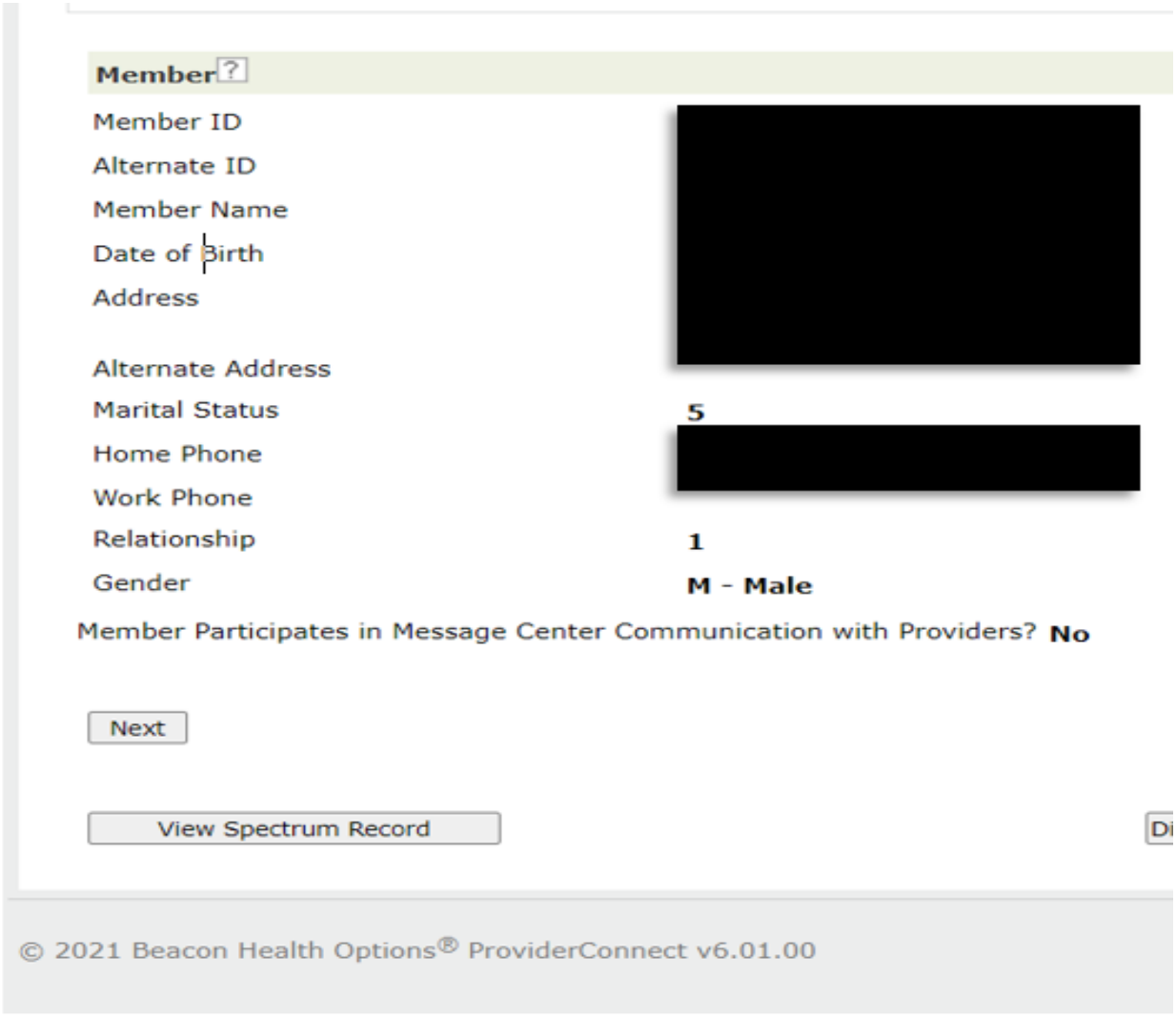
Enter the Member ID and Date of Birth to search for the member



Member Demographics

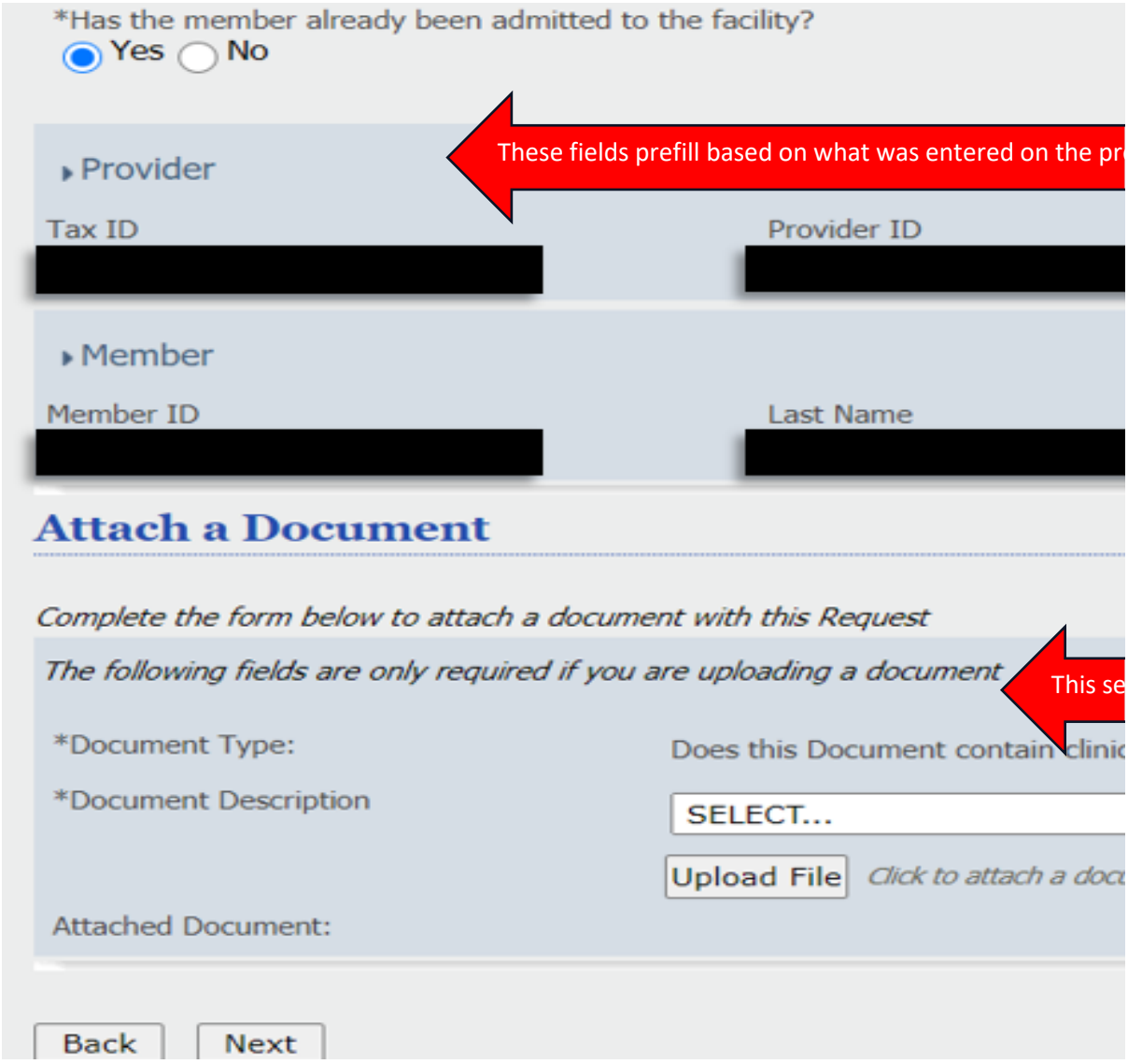
The next screen will prefill with the eligible members information, confirm you have the correc



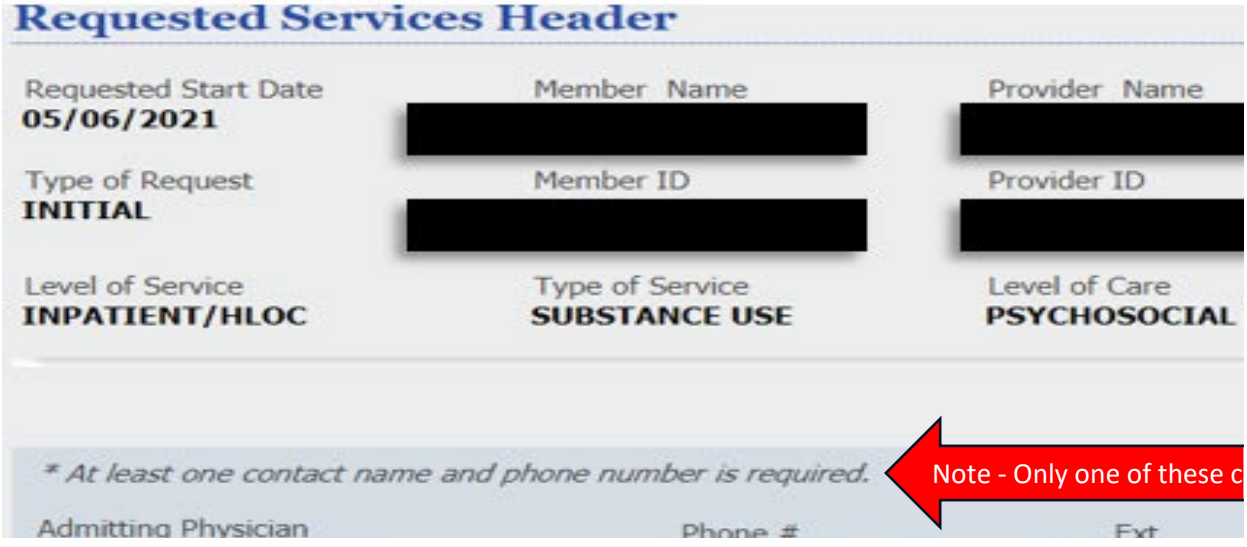


Requested Service

Enter all information with an *



Notification Form - Initial Request



Preparer

Phone #

Ext

Primary Care Coordination

PCP Contacted Status

SELECT...

PCP Contacted Name

Date Contacted

Is the Member in active treatment with a behavioral health provider?

Yes No Unknown

Is there documentation of Member's consent to allow communication with PCP and aft

Yes No

Diagnosis

*Documentation of **primary behavioral condition** is required. Provisional working condition and di health, substance use, personality, intellectual disability) is strongly recommended to support compr in the members plan and/or summary plan description including covered diagnoses.*

Behavioral Diagnoses

Primary Behavioral Diagnosis

* Diagnostic Category 1

SELECT...

* Diagnosis Co

Additional Behavioral Diagnosis

Diagnostic Category 2

SELECT...

Diagnosis Code

Diagnostic Category 3

SELECT...

Diagnosis Code

Diagnostic Category 4

SELECT...

Diagnosis Code

Diagnostic Category 5

SELECT...

Diagnosis Code

Primary Medical Diagnosis

Primary medical diagnosis is required. Select primary medical diagnostic category from dropdown or

* Diagnostic Category 1

SELECT...

Diagnosis Code

Diagnostic Category 1 is a required field, You can

Diagnostic Category 2

SELECT...

Diagnosis Code

Diagnostic Category 3

SELECT...

Diagnosis Code

Social Elements Impacting Diagnosis

* Check all that apply

- [ ] None
- [ ] Problems with access to health care services
- [ ] Educational problems
- [ ] Problems related to interaction w/legal system/crime
- [ ] Financial problems
- [ ] Problems with primary support group
- [ ] Other psychosocial and environmental problems

Functional Assessment

Please indicate the functional assessment tool utilized or select Other to write in other specific tool. A should be noted in the Assessment Score field.

Assessment Measure

SELECT...

Assessment Score

ASAM Criteria

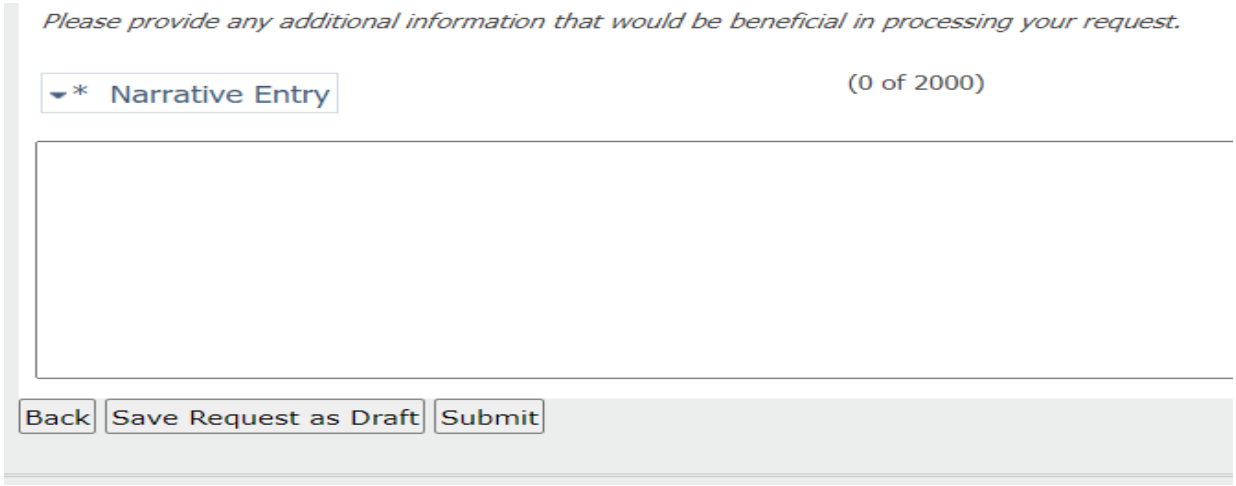
Low = member's motivation to engage in treatment and move through the stages of change

Dimension 1	Dim
Intoxication/Withdrawal Potential	Biomedi
◯ Low ◯ Medium ◯ High	◯ Lo
Dimension 4	Dim
Readiness To Change	Relapse
◯ Low ◯ Medium ◯ High	◯ Lo

Projected Duration and Frequency of Treatment

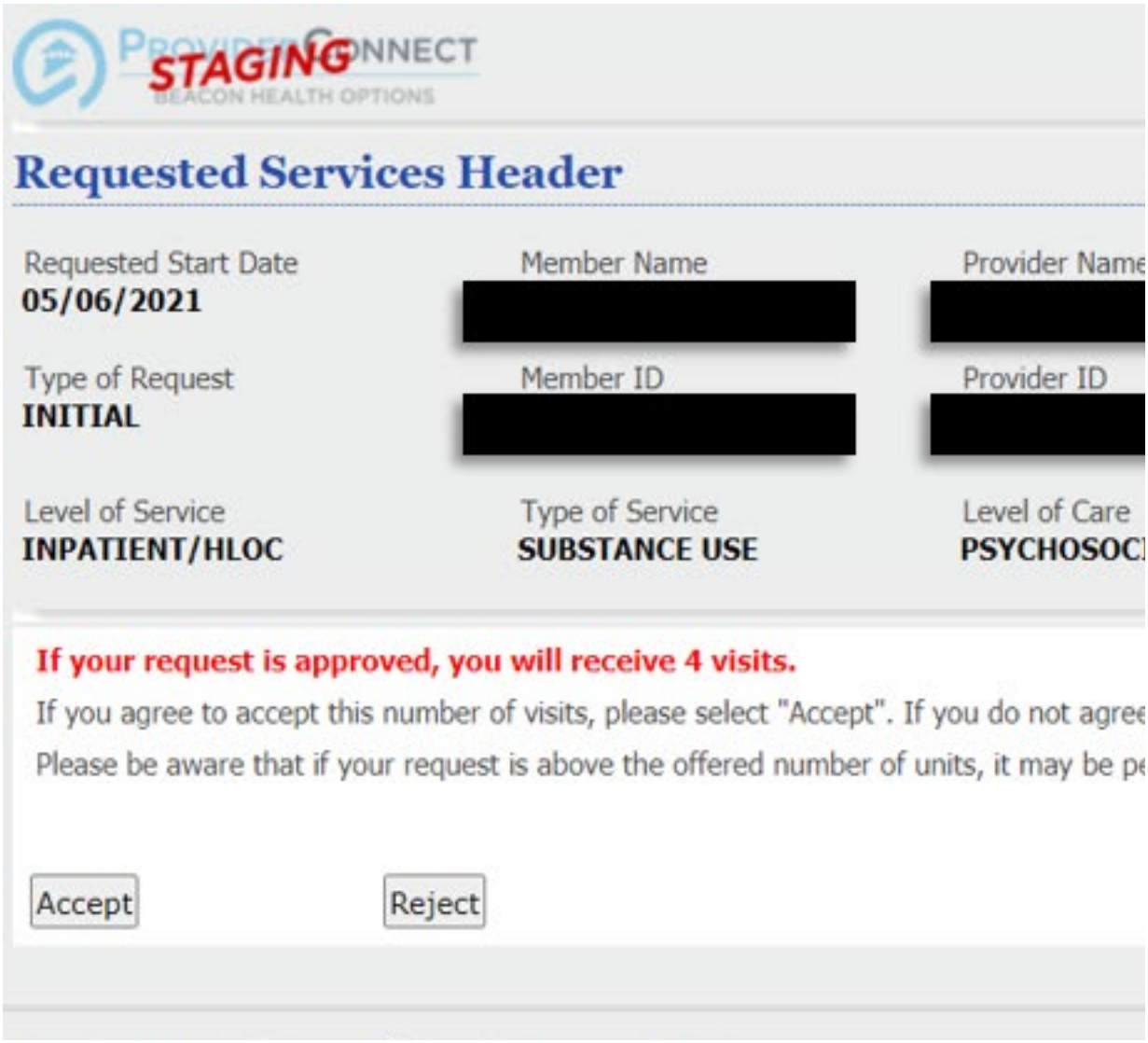
Projected Date of Discharge

Estimate



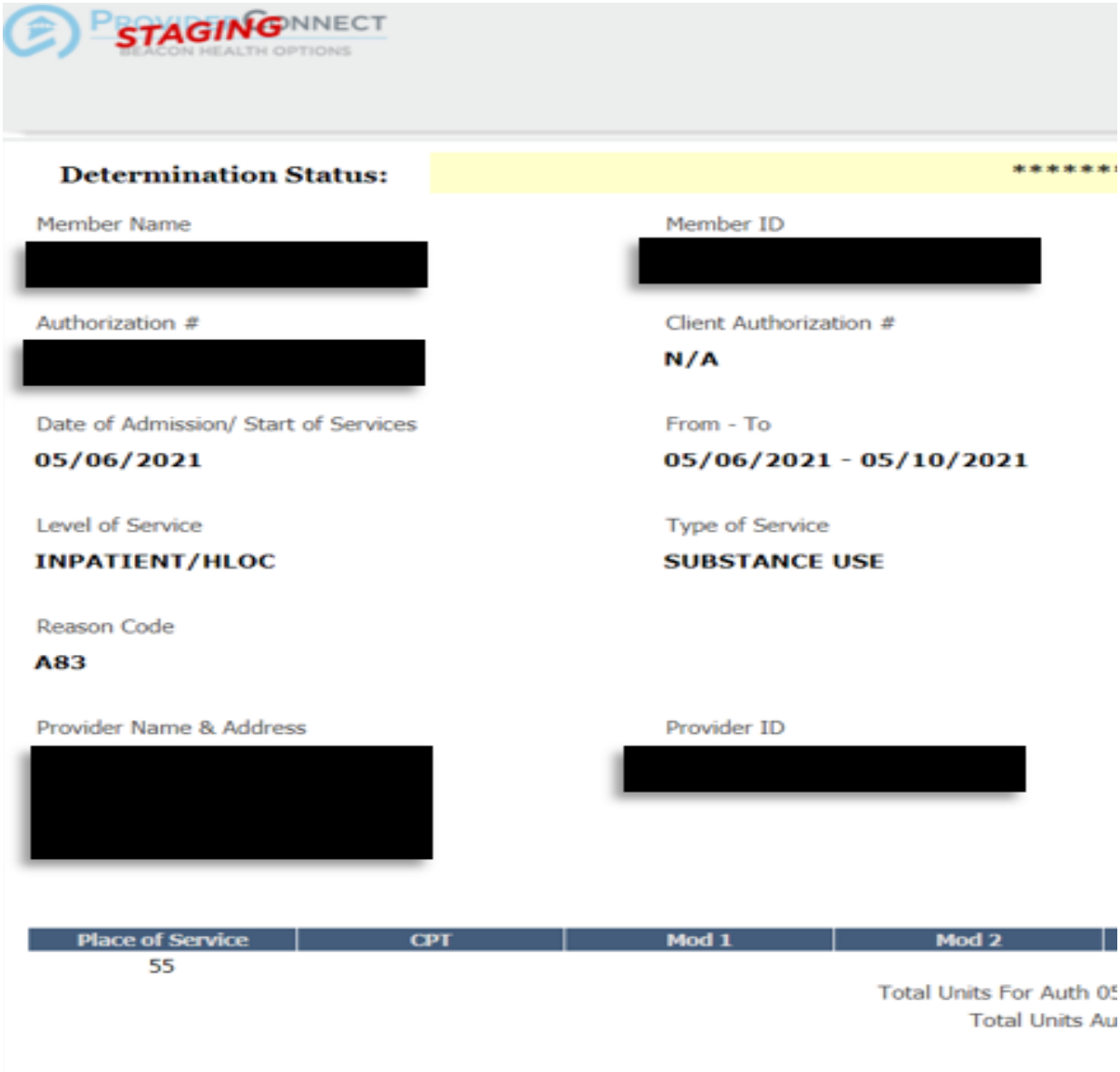
Automated confirmation of number of visits

Review and click Accept at the bottom of the screen

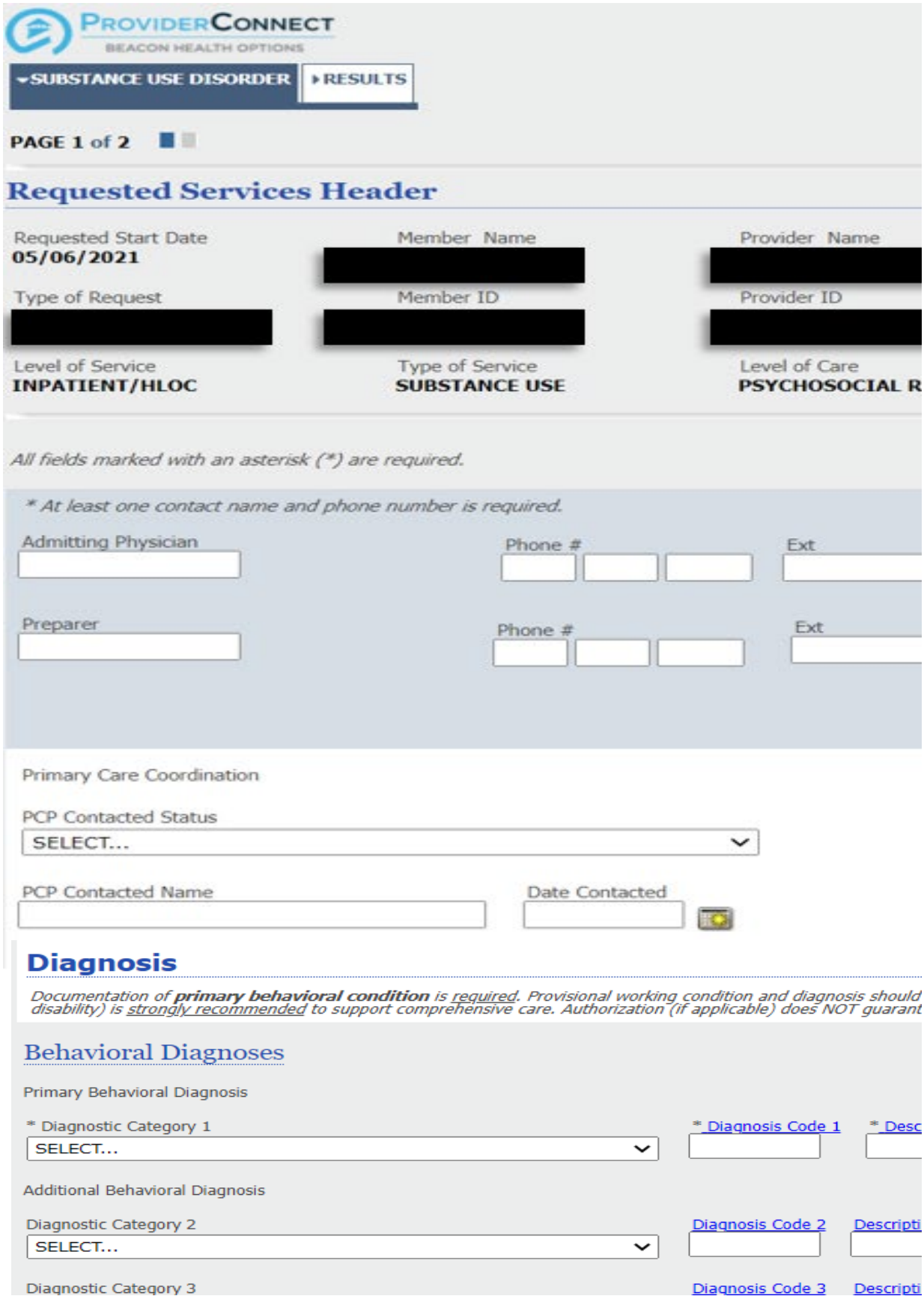


Automated Results

If the system is able to approve the request (which should be the majority of cases) this will be
If the system is not able to automatically approve the request this screen will showing pending
You can print or upload this approval screen.
***Authorizations will automically prefill with a place of service of 49, please bill these service



Substance Use - Continued Stay Review



SELECT...

Diagnostic Category 4
SELECT...

Diagnosis Code 4

Descripti

Diagnostic Category 5
SELECT...

Diagnosis Code 5

Descripti

Primary Medical Diagnosis

Primary medical diagnosis is required. Select primary medical diagnostic category from dropdown or select medical

* Diagnostic Category 1
SELECT...

Diagnosis Code 1

Descripti

Diagnostic Category 2
SELECT...

Diagnosis Code 2

Descripti

Diagnostic Category 3
SELECT...

Diagnosis Code 3

Descripti

Please provide any additional information that would be beneficial in processing your request.

Narrative Entry

(0 of 2000)

Note: Disable pop-up blocker functionality to view all appropriate links.

Current Risks

Key:

0 = None **1** = Mild or Mildly Incapacitating **2** = Moderate or Moderately Incapacitating

*Member`s Risk to Self

0 1 2 3 N/A

*Member`s Risk to Others

0 1 2

CIWA

N/A

COWS

N/A

Pulse

Pulse Rate is recommended when CIWA is entered.

* Is member experiencing symptoms of withdrawal or at risk of experiencing symptoms of

If yes, describe: (0 of 250)

* Has Ambulatory Withdrawal Management been considered for placement? ◯ Yes ◯

* If no, what makes less restrictive placement inappropriate at this time?

- ☐ Member requires medication and has recent history of not completing withdrawal management at less intensive level of care.
- ☐ Member has recent management and ha withdrawal manage
- ☐ Member has co-morbid physical, emotional, behavioral or cognitive symptoms of such severity that complicate withdrawal management.
- ☐ Withdrawal manage intervention more fr

* Does member have any significant medical risks that require 24 hour monitoring by a me

If yes, describe: (0 of 250)

* Describe member`s Current Readiness to Change

◯ Pre-Contemplative ◯ Contemplative

◯ Action ◯ Maintenance

* Member`s Living Situation

Please select most appropriate member`s Living Situation as it relates to member`s recovery.

◯ Homelessness ◯ Social supports do not support recovery ◯

◯ High risk of abuse or neglect ◯ Secure housing ◯

Note: Disable pop-up blocker functionality to view all appropriate links.

ASAM Criteria

Please indicate risk rating along the 6 dimensions of the ASAM Criteria. A risk rating of 0 indicates full functioning and no ri

Dimension 1	Dimension 2
Acute Intoxication and/or Withdrawal Potential:	Biomedical Condition
◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4	◯ 0 ◯ 1 ◯ 2
Dimension 4	**Dimension 5**
Readiness to Change: *N/A is only applicable to detoxification.*	Relapse, Continued U *N/A is only applicabl*
◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4A ◯ 4B ◯ N/A	◯ 0 ◯ 1 ◯ 2

Please provide any additional ASAM information.

▾Narrative Entry (0 of 2000)


Back
Save Request as Draft
Submit

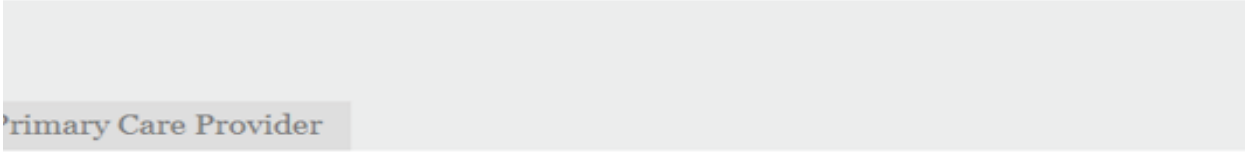
ng Beacon Health Options ProviderConnect.

Your inbox is empty

e ease in which you can interact with us by developing online communications solutions. Using
ing laws.

ria below.

t member information selected.



d is provided by our clients.

Eligibility

Effective Date

Expiration Date

COB Effective Date

Subscriber

Subscriber ID

Subscriber Name

isable Member Communication

Date to begin. Please review the Member's benefit coverage before creating this requ

*Level of Service

INPATIENT/HLOC/SPECIALTY

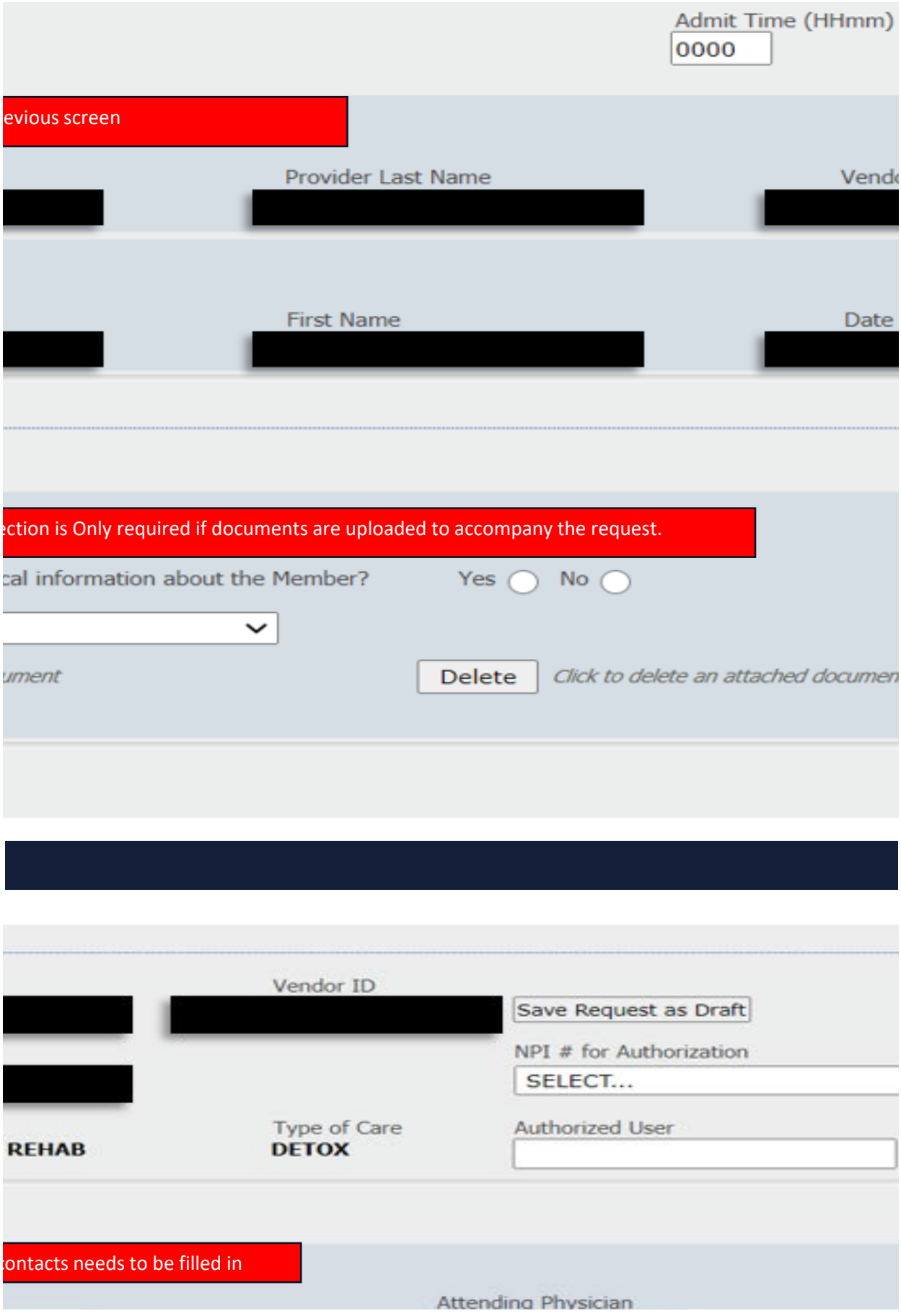
IAL REHAB

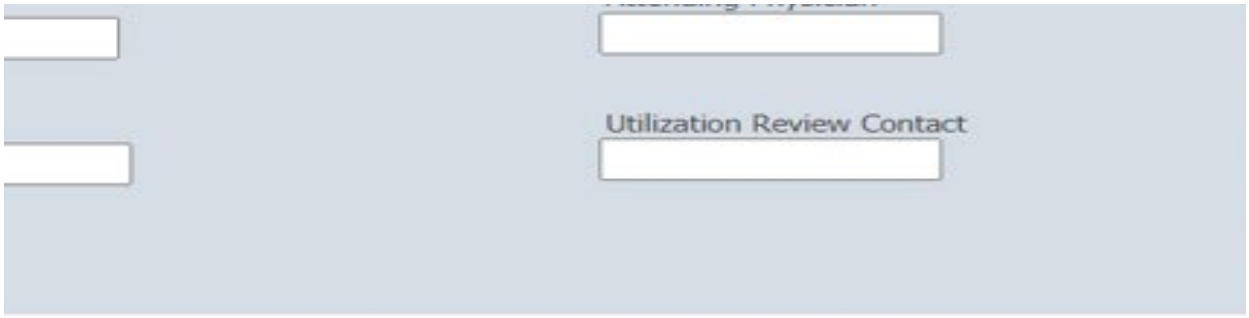
*Type of Care

DETOX

*Admit Date (MMDD

05052021

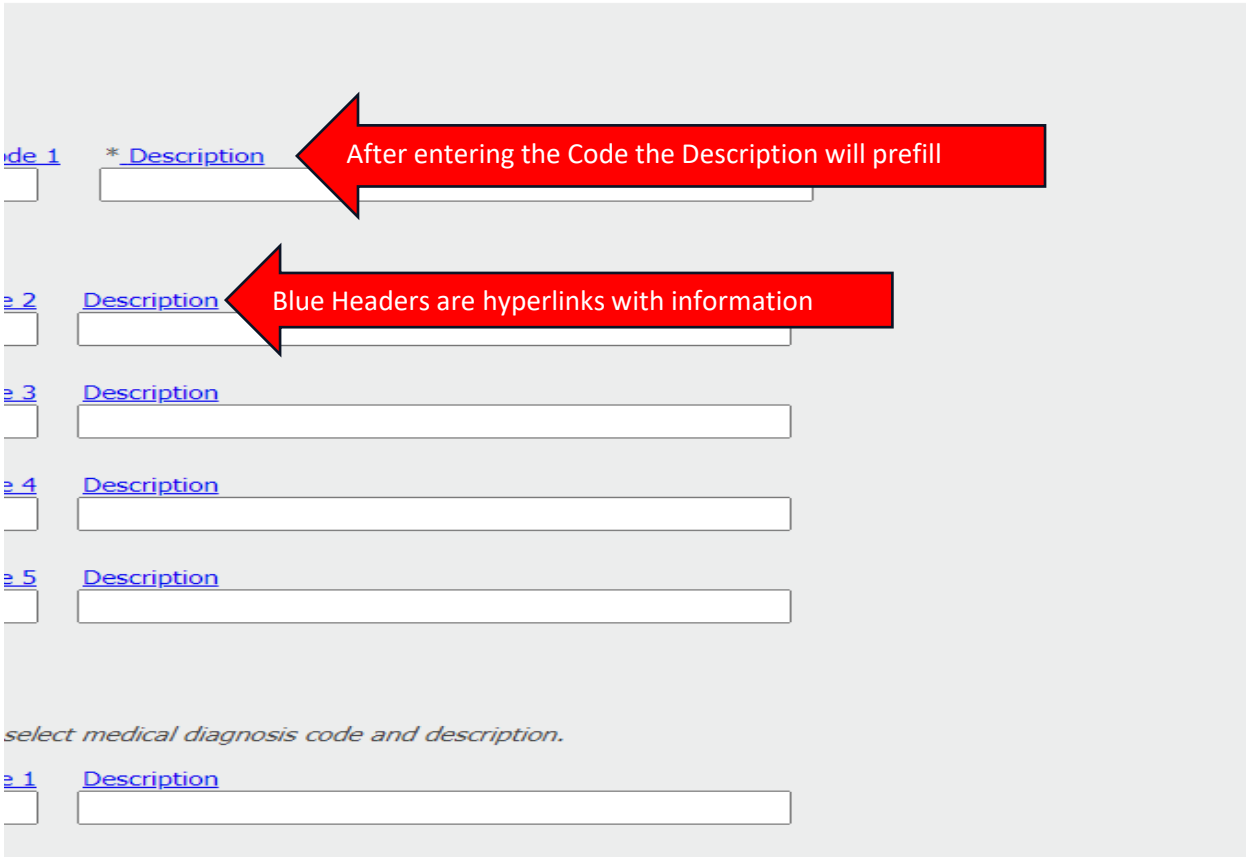

Admit Time (HHmm)
0000
evious screen
Provider Last Name
Vend
First Name
Date
ction is Only required if documents are uploaded to accompany the request.
cal information about the Member?
Yes
No
ument
Delete
Click to delete an attached documen
Vendor ID
Save Request as Draft
NPI # for Authorization
SELECT...
Type of Care
REHAB
DETOX
Authorized User
ontacts needs to be filled in
Attending Physician



nly required if the PCP was contacted and status selected

ercare providers?

*iagnosis should be documented if necessary. Documentation of **secondary co-occurring** behavioral*
rehensive care. Authorization (if applicable) does NOT guarantee payment of benefits for these service



e 2 Description

e 3 Description

- [ ] Housing problems (Not Homelessness)
- [ ] Occupational problems
- [ ] Unknown

4ssessment score for specific tool

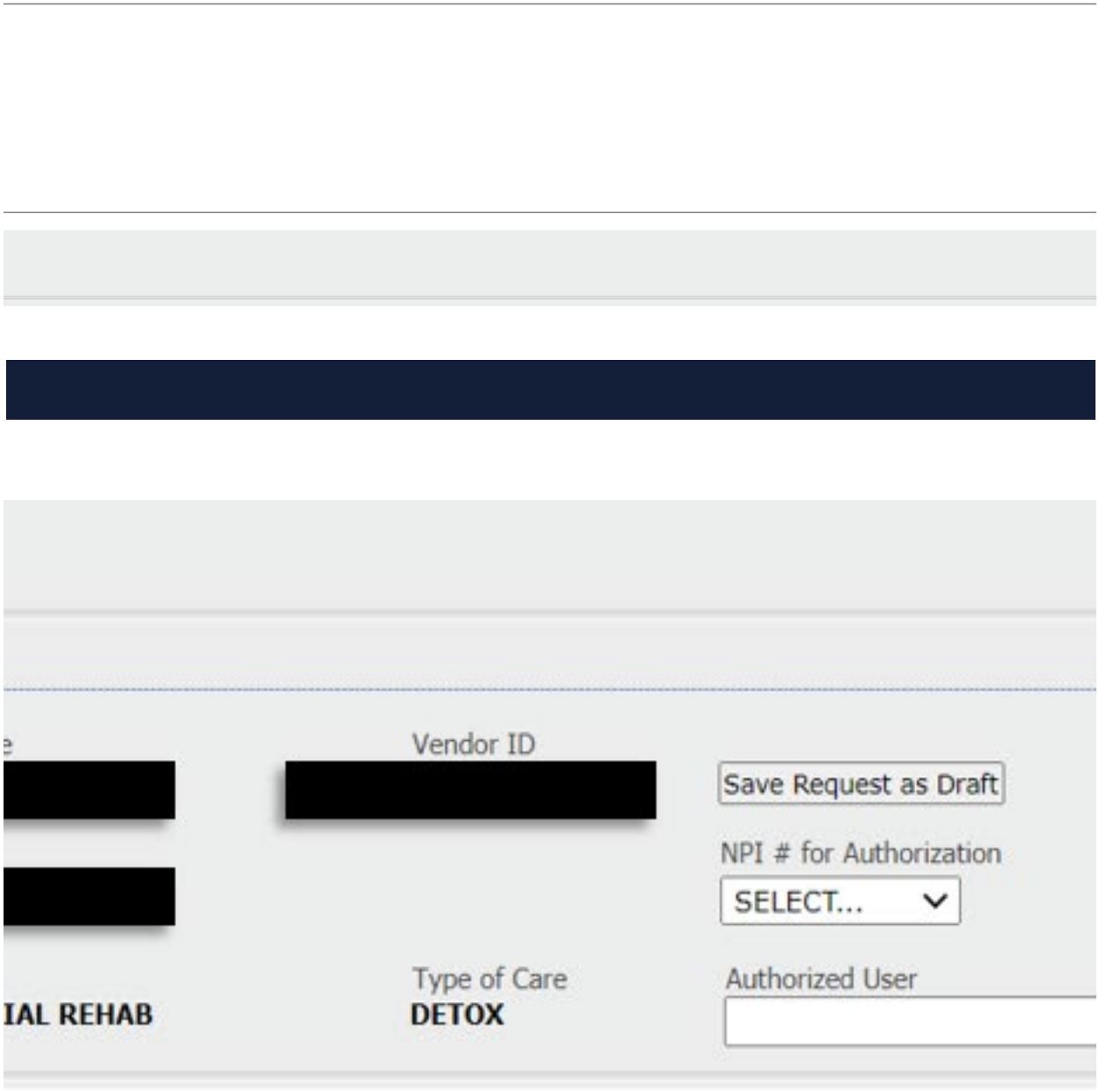
Secondary Assessment Measure

SELECT...

Assessm

ension 2	Dimension 3
cal Conditions	Emot/Beh/Cogn Conditi
w ◯ Medium ◯ High	◯ Low ◯ Medium
ension 5	Dimension 6
Potential	Recovery Environment
w ◯ Medium ◯ High	◯ Low ◯ Medium

d Number of Units


Vendor ID
Save Request as Draft
NPI # for Authorization
SELECT...
Type of Care
DETOX
Authorized User
IAL REHAB
, please select "Reject" and you may enter your modified request.
ended for additional clinical review.

the next screen.
and it will go to a clinical represenative for review.

s with a place of service of 49. Should you need a different place of service code listed you will r

********** APPROVED **********

Member DOB
[redacted]

Subscriber Name
[redacted]

Type of Request
INITIAL

Submission Date
05/06/2021

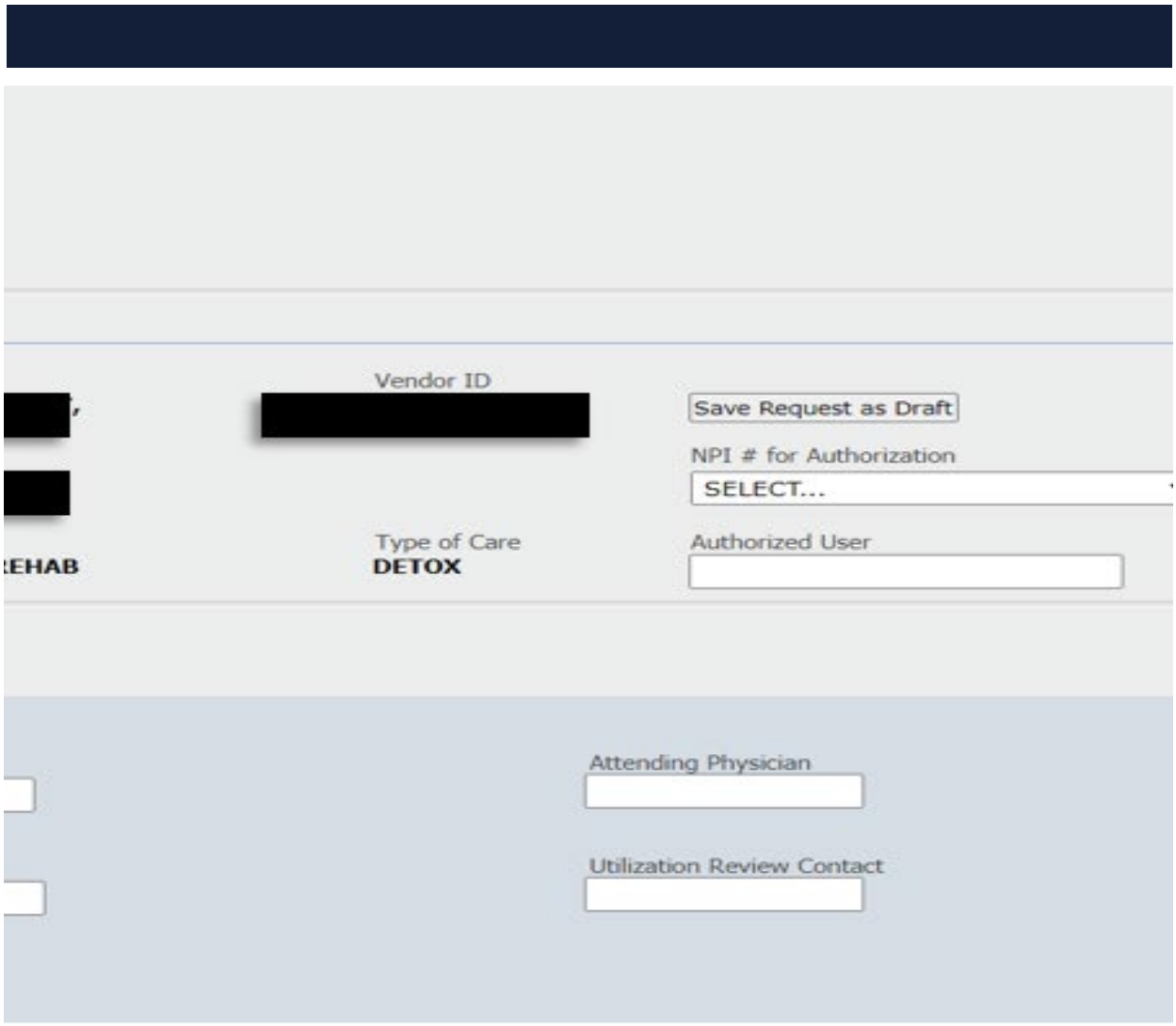
Level of Care
PSYCHOSOCIAL REHABILITATION

Type of Care
DETOX

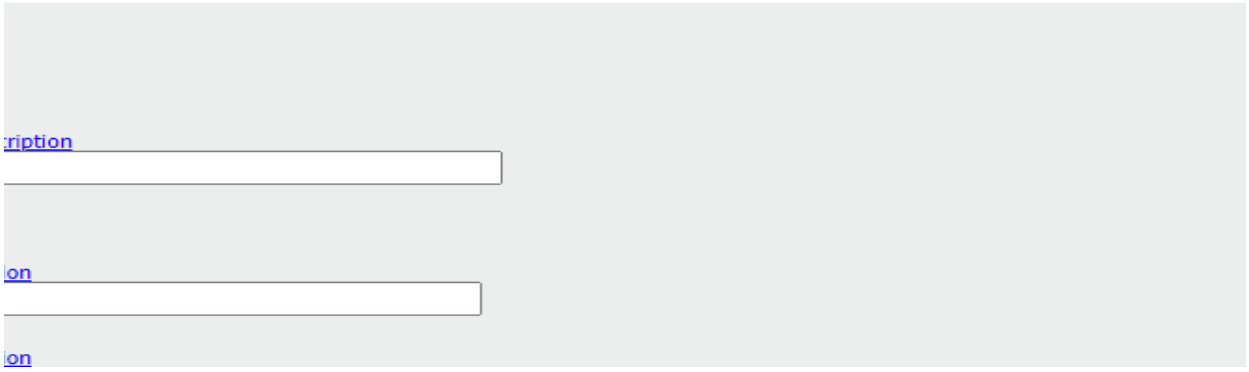
NPI # for Authorizatic
N/A

Mod 3	Mod 4	Service Class	Description
		SOP	STRUCTURED OUTPA

50621-1-9 From 05/06/2021 To 05/10/2021
thorized This Episode For 050621-1-9



*be documented if necessary. Documentation of **secondary co-occurring** behavioral conditions that impact or are a fo*
tee payment of benefits for these services. Coverage is subject to all limits and exclusions outlined in the members plan



ion

ion

diagnosis code and description.

ion

ion

ion

3 = Severe or Severely Incapacitating **N/A** = Not Assessed

*Psychosis/ Hallucinations/ Delusions

3 ◯ N/A

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ N/A

withdrawal if not treated? ◯ Yes ◯ No

No ◯ N/A

history of withdrawal
as insufficient skills to complete
ment and enter continuing care.

ment requires monitoring or
equently than hourly.

edical team? ◯ Yes ◯ No

◯ Preparation

Social supports engaged in active substance use ◯ Social isolation

Social supports are supportive of recovery ◯ Secure social network ◯ Other

isk in the dimension. Risk ratings 1-4 indicate increasing levels of risk and severity. Note for dimensions 4-6 additional rating of 4

	Dimension 3
ns and Complications:	Emotional, Behavioral, or Cognitive Conditions
2 ◯ 3 ◯ 4	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4
	Dimension 6
Use, or Continued Problem Potential: *le to detoxification.*	Recovery/Living Environment: *N/A is only applicable to detoxification.*
2 ◯ 3 ◯ 4A ◯ 4B ◯ N/A	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4A ◯ 4B

Enter or Review Referrals

- Review Referrals

nter Bed Tracking Information

earch Beds/Openings

iew My Recent Authorization Letters

ProviderConnect allows you to accomplish an array of daily tra

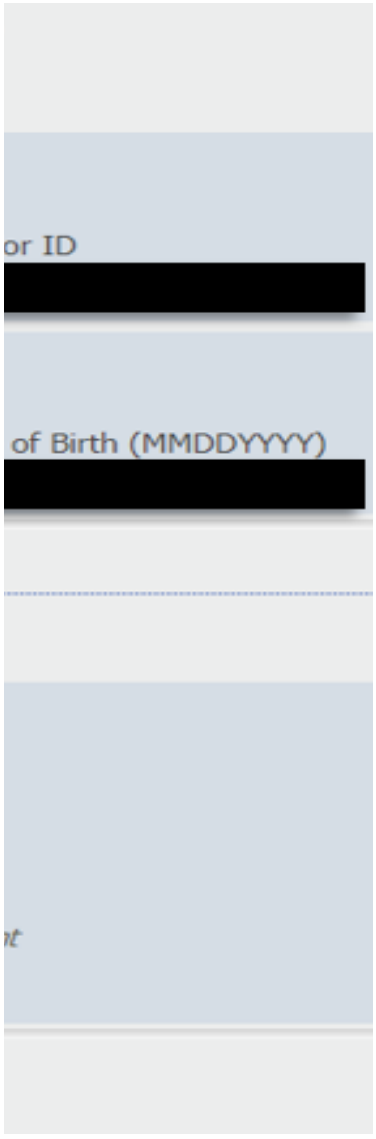
06/17/2020

[redacted]

[redacted]

est.

YYYY)


or ID
of Birth (MMDDYYYY)


Ext

conditions that impact or are a focus of treatment (mental
es. Coverage is subject to all limits and exclusions outlined

- [ ] Problems related to the social environment
- [ ] Homelessness
- [ ] Medical disabilities that impact diagnosis or must be accommodated for in treatment

ıent Score

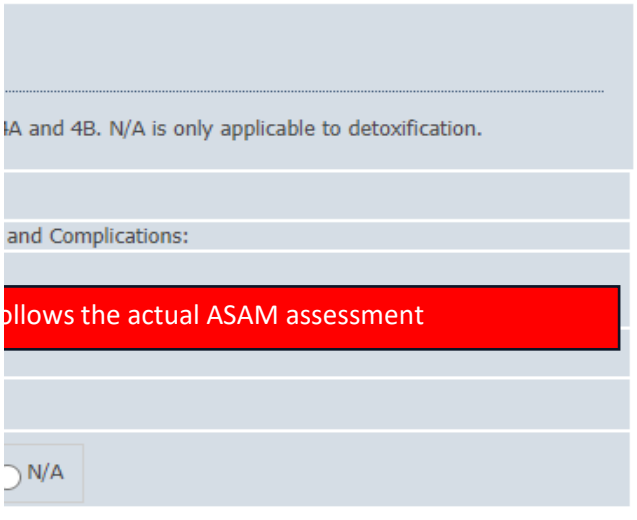
ions

- ◯ High

- ◯ High

ıeed to call and adjust the authorization prior to billing claims.

ocus of treatment (mental health, substance use, personality, intellectual and/or summary plan description including covered diagnoses.


4A and 4B. N/A is only applicable to detoxification.
and Complications:
ollows the actual ASAM assessment
N/A