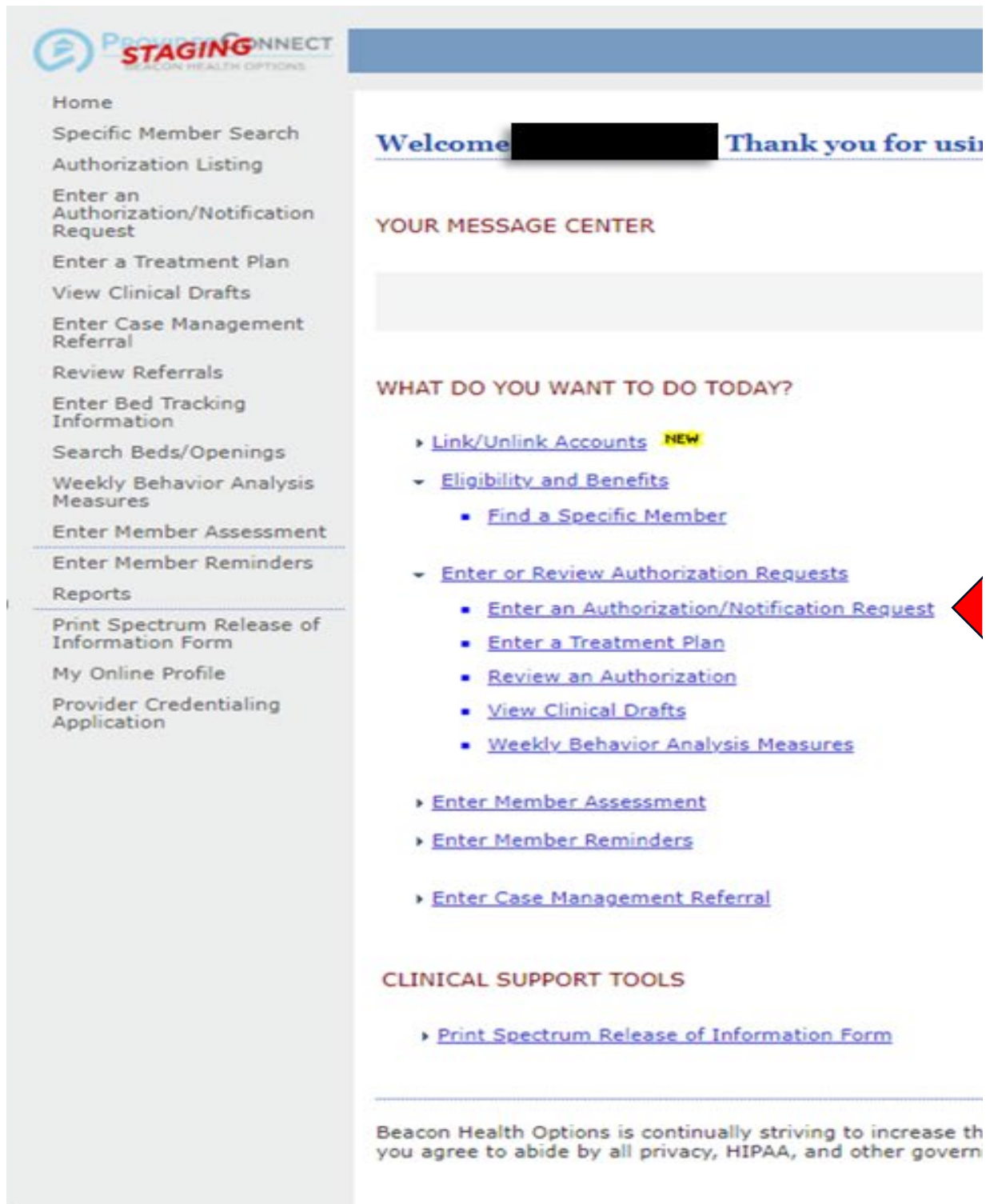


# Provider Connect - Main Menu

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



The screenshot displays the Provider Connect main menu. On the left is a vertical sidebar with a list of navigation options. The main content area on the right features a welcome message, a message center, a list of tasks under 'WHAT DO YOU WANT TO DO TODAY?', and a section for 'CLINICAL SUPPORT TOOLS'. A red arrow points to the 'Enter an Authorization/Notification Request' link in the task list.

**Provider Connect**  
STAGING  
BEACON HEALTH OPTIONS

Home  
Specific Member Search  
Authorization Listing  
Enter an Authorization/Notification Request  
Enter a Treatment Plan  
View Clinical Drafts  
Enter Case Management Referral  
Review Referrals  
Enter Bed Tracking Information  
Search Beds/Openings  
Weekly Behavior Analysis Measures  
Enter Member Assessment  
Enter Member Reminders  
Reports  
Print Spectrum Release of Information Form  
My Online Profile  
Provider Credentialing Application

Welcome [REDACTED] Thank you for using

**YOUR MESSAGE CENTER**

**WHAT DO YOU WANT TO DO TODAY?**

- ▶ [Link/Unlink Accounts](#) **NEW**
- ▼ [Eligibility and Benefits](#)
  - [Find a Specific Member](#)
- ▼ [Enter or Review Authorization Requests](#)
  - [Enter an Authorization/Notification Request](#)
  - [Enter a Treatment Plan](#)
  - [Review an Authorization](#)
  - [View Clinical Drafts](#)
  - [Weekly Behavior Analysis Measures](#)
- ▶ [Enter Member Assessment](#)
- ▶ [Enter Member Reminders](#)
- ▶ [Enter Case Management Referral](#)


**CLINICAL SUPPORT TOOLS**

- ▶ [Print Spectrum Release of Information Form](#)

Beacon Health Options is continually striving to increase th  
you agree to abide by all privacy, HIPAA, and other govern

## Member Search

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



### Search a Member

Required fields are denoted by an asterisk ( \* ) adjacent to the label.


Verify a patient's eligibility and benefits information by entering search criteria

*Member ID	<input type="text"/>	(No spaces or dashes)
Last Name	<input type="text"/>	
First Name	<input type="text"/>	
*Date of Birth	<input type="text"/>	(MMDDYYYY)
As of Date	<input type="text" value="05052021"/>	(MMDDYYYY)

© 2021 Beacon Health Options® ProviderConnect v6.01.00

## Member Demographics

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



Demographics Enrollment History COB Additional Information P

Member eligibility does not guarantee payment. Eligibility is as of today's date and

## Member?

Member ID

Alternate ID

Member Name

Date of Birth

Address

Alternate Address

Marital Status

Home Phone

Work Phone

Relationship

Gender

5

1

M - Male

Member Participates in Message Center Communication with Providers? **No**

Next

View Spectrum Record

Di

© 2021 Beacon Health Options® ProviderConnect v6.01.00

## Requested Service

Enter all information with an \*



### Requested Services Header

*All fields marked with an asterisk (\*) are required. Select the Requested Start Date. Note: Disable pop-up blocker functionality to view all appropriate links.*

\*[Requested Start Date](#) (MMDDYYYY) \*

05052021



\*Type of Service

SUBSTANCE USE ▼

\*[Level of Care](#)

PSYCHOSOC

\*Has the member already been admitted to the facility?  
☒ Yes ☐ No

► Provider

Tax ID  Provider ID

► Member

Member ID  Last Name

### Attach a Document

*Complete the form below to attach a document with this Request*

*The following fields are only required if you are uploading a document*

\*Document Type:  Does this Document contain clinical information?

\*Document Description

*Click to attach a document*

Attached Document:


## Notification Form - Initial Request

### Requested Services Header

Requested Start Date <b>05/06/2021</b>	Member Name <input type="text"/>	Provider Name <input type="text"/>
Type of Request <b>INITIAL</b>	Member ID <input type="text"/>	Provider ID <input type="text"/>
Level of Service <b>INPATIENT/HLOC</b>	Type of Service <b>SUBSTANCE USE</b>	Level of Care <b>PSYCHOSOCIAL</b>

\* At least one contact name and phone number is required.

Admitting Physician  Phone #  Ext.

Preparer		Phone #		Ext
<input type="text"/>		<input type="text"/>		<input type="text"/>
PCP Contacted Status		SELECT...		
PCP Contacted Name		Date Contacted		
<input type="text"/>		<input type="text"/>		
Is the Member in active treatment with a behavioral health provider?				
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				
Is there documentation of Member's consent to allow communication with PCP and aft				
<input type="radio"/> Yes <input type="radio"/> 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 s

\* 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

☐ Educational problems

☐ Financial problems

☐ Other psychosocial and  
environmental problems

☐ Problems with access to  
health care services

☐ Problems related to interaction  
w/legal system/crime

☐ Problems with primary support  
group

## 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

### [Dimension 1](#)

Intoxication/Withdrawal Potential

☐ Low ☐ Medium ☐ High

### [Dimension 4](#)

Readiness To Change

☐ Low ☐ Medium ☐ High

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

## Projected Duration and Frequency of Treatment

Projected Date of Discharge



Estimate

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

▼ \* Narrative Entry

(0 of 2000)


Back

Save Request as Draft

Submit

## Automated confirmation of number of visits

Review and click Accept at the bottom of the screen



**STAGING**CONNECT  
SEACON HEALTH OPTIONS

### Requested Services Header

Requested Start Date <b>05/06/2021</b>	Member Name [REDACTED]	Provider Name [REDACTED]
Type of Request <b>INITIAL</b>	Member ID [REDACTED]	Provider ID [REDACTED]
Level of Service <b>INPATIENT/HLOC</b>	Type of Service <b>SUBSTANCE USE</b>	Level of Care <b>PSYCHOSOCIAL</b>

**If your request is approved, you will receive 4 visits.**

If you agree to accept this number of visits, please select "Accept". If you do not agree, please select "Reject". Please be aware that if your request is above the offered number of units, it may be partially approved.

Accept


Reject



## 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 automatically prefill with a place of service of 49, please bill these services

**STAGING**  
BEACON HEALTH OPTIONS

**Determination Status:** \*\*\*\*\*1


Member Name	Member ID
[REDACTED]	[REDACTED]
Authorization #	Client Authorization #
[REDACTED]	<b>N/A</b>
Date of Admission/ Start of Services	From - To
<b>05/06/2021</b>	<b>05/06/2021 - 05/10/2021</b>
Level of Service	Type of Service
<b>INPATIENT/HLOC</b>	<b>SUBSTANCE USE</b>
Reason Code	
<b>A83</b>	
Provider Name & Address	Provider ID
[REDACTED]	[REDACTED]

Place of Service	CPT	Mod 1	Mod 2
55			

Total Units For Auth 05  
Total Units Au



# Substance Use - Continued Stay Review

**PROVIDERCONNECT**  
BEACON HEALTH OPTIONS

**↳ SUBSTANCE USE DISORDER** **▶ RESULTS**

PAGE 1 of 2

## Requested Services Header

Requested Start Date <b>05/06/2021</b>	Member Name [REDACTED]	Provider Name [REDACTED]
Type of Request [REDACTED]	Member ID [REDACTED]	Provider ID [REDACTED]
Level of Service <b>INPATIENT/HLOC</b>	Type of Service <b>SUBSTANCE USE</b>	Level of Care <b>PSYCHOSOCIAL R</b>

All fields marked with an asterisk (\*) are required.


*\* At least one contact name and phone number is required.*

Admitting Physician [REDACTED]	Phone # [REDACTED] [REDACTED] [REDACTED]	Ext [REDACTED]
Preparer [REDACTED]	Phone # [REDACTED] [REDACTED] [REDACTED]	Ext [REDACTED]

Primary Care Coordination

PCP Contacted Status  
SELECT... ▼

PCP Contacted Name  
[REDACTED]

Date Contacted  
[REDACTED] 

## Diagnosis

Documentation of **primary behavioral condition** is required. Provisional working condition and diagnosis should (disability) is strongly recommended to support comprehensive care. Authorization (if applicable) does NOT guarant

### Behavioral Diagnoses

Primary Behavioral Diagnosis

* Diagnostic Category 1 SELECT... ▼	* <a href="#">Diagnosis Code 1</a> [REDACTED]	* <a href="#">Desc</a> [REDACTED]
----------------------------------------	--------------------------------------------------	--------------------------------------

Additional Behavioral Diagnosis

Diagnostic Category 2 SELECT... ▼	<a href="#">Diagnosis Code 2</a> [REDACTED]	<a href="#">Descripti</a> [REDACTED]
Diagnostic Category 3	<a href="#">Diagnosis Code 3</a>	<a href="#">Descripti</a>

SELECT... ▼

Diagnostic Category 4

[Diagnosis Code 4](#)

[Description](#)

SELECT... ▼

Diagnostic Category 5

[Diagnosis Code 5](#)

[Description](#)

SELECT... ▼

## Primary Medical Diagnosis

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

\* Diagnostic Category 1

[Diagnosis Code 1](#)

[Description](#)

SELECT... ▼

Diagnostic Category 2

[Diagnosis Code 2](#)

[Description](#)

SELECT... ▼

Diagnostic Category 3

[Diagnosis Code 3](#)

[Description](#)

SELECT... ▼

*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](#)

\*[Member`s Risk to Others](#)

☐ 0   ☐ 1   ☐ 2   ☐ 3   ☐ N/A

☐ 0   ☐ 1   ☐ 2   ☐

[CIWA](#)

[COWS](#)

☐ N/A

☐ 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?

- |                                                                                                                                                             |                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| <input type="checkbox"/> Member requires medication and has recent history of not completing withdrawal management at less intensive level of care.         | <input type="checkbox"/> Member has recent management and has withdrawal management |
| <input type="checkbox"/> Member has co-morbid physical, emotional, behavioral or cognitive symptoms of such severity that complicate withdrawal management. | <input type="checkbox"/> Withdrawal management 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

- |                                                         |                                                     |
|---------------------------------------------------------|-----------------------------------------------------|
| <input type="radio"/> <a href="#">Pre-Contemplative</a> | <input type="radio"/> <a href="#">Contemplative</a> |
| <input type="radio"/> <a href="#">Action</a>            | <input type="radio"/> <a href="#">Maintenance</a>   |

\* Member`s Living Situation

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

- |                                                     |                                                               |                       |
|-----------------------------------------------------|---------------------------------------------------------------|-----------------------|
| <input type="radio"/> Homelessness                  | <input type="radio"/> Social supports do not support recovery | <input type="radio"/> |
| <input type="radio"/> High risk of abuse or neglect | <input type="radio"/> Secure housing                          | <input type="radio"/> |

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 r

<a href="#">Dimension 1</a>	<a href="#">Dimension 2</a>
Acute Intoxication and/or Withdrawal Potential:	Biomedical Condition
<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
<a href="#">Dimension 4</a>	<a href="#">Dimension 5</a>
Readiness to Change: <i>N/A is only applicable to detoxification.</i>	Relapse, Continued Use <i>N/A is only applicable to detoxification.</i>
<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4A <input type="radio"/> 4B <input type="radio"/> N/A	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 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

▼ In

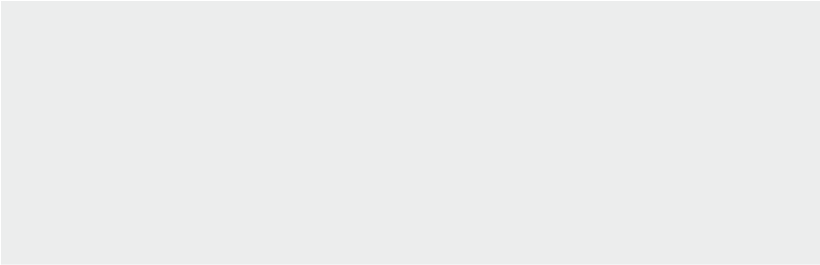
▶ M

▶ S

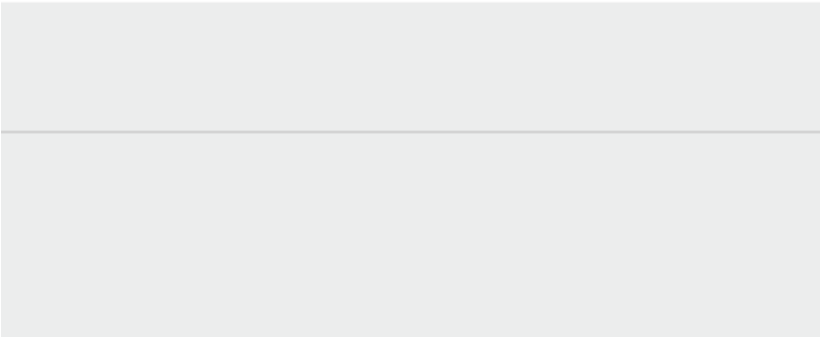
▶ V



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



eria below.



st member information selected.

Primary Care Provider

nd is provided by our clients.

Eligibility

Effective Date  
Expiration Date  
COB Effective Date?

Subscriber

Subscriber ID  
Subscriber Name

Disable Member Communication

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

Level of Service  
INPATIENT/HLOC/SPECIALTY

INPATIENT REHAB

\*Type of Care  
DETOX

\*Admit Date (MMDDYY)  
05052021



Admit Time (HHmm)

0000

previous screen

Provider Last Name

Vendor

First Name

Date

Section is Only required if documents are uploaded to accompany the request.

Additional information about the Member?

Yes

☐

No

☐

Document

Delete

Click to delete an attached document

Vendor ID

Save Request as Draft

NPI # for Authorization

SELECT...

Type of Care

Authorized User

REHAB

DETOX

contacts needs to be filled in

Attending Physician

<input type="text"/>	<input type="text"/>
<input type="text"/>	Utilization Review Contact <input type="text"/>

Only required if the PCP was contacted and status selected

ercare providers?

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

Code 1	*_Description	After entering the Code the Description will prefill
<input type="text"/>	<input type="text"/>	
Code 2	Description	Blue Headers are hyperlinks with information
<input type="text"/>	<input type="text"/>	
Code 3	Description	
<input type="text"/>	<input type="text"/>	
Code 4	Description	
<input type="text"/>	<input type="text"/>	
Code 5	Description	
<input type="text"/>	<input type="text"/>	

Select medical diagnosis code and description.

Code 1	Description
<input type="text"/>	<input type="text"/>

<a href="#">e 2</a>	<a href="#">Description</a>	
<a href="#">e 3</a>	<a href="#">Description</a>	

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

Assessment score for specific tool

Secondary Assessment Measure

SELECT... ▼

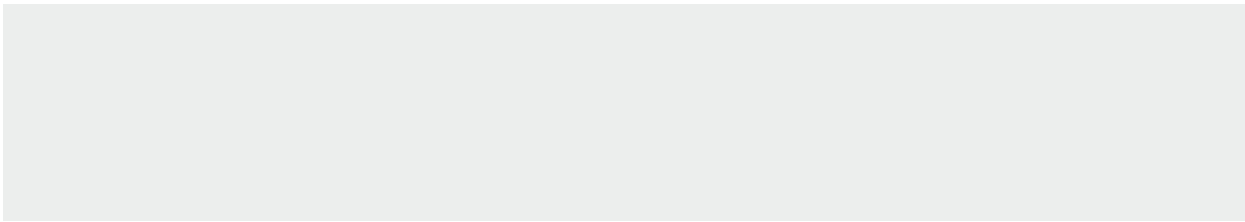
Assessm

<a href="#">Dimension 2</a>	<a href="#">Dimension 3</a>
cal Conditions	Emot/Beh/Cogn Condi
Low <input type="radio"/> Medium <input type="radio"/> High	<input type="radio"/> Low <input type="radio"/> Medium
<a href="#">Dimension 5</a>	<a href="#">Dimension 6</a>
Potential	Recovery Environment
Low <input type="radio"/> Medium <input type="radio"/> High	<input type="radio"/> Low <input type="radio"/> Medium

Number of Units

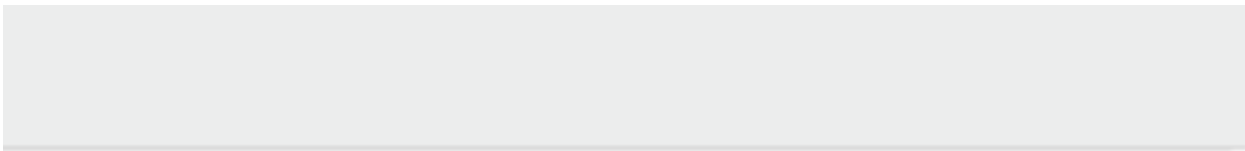
<div>Vendor ID</div> <div></div>	<div>Save Request as Draft</div>
<div>NPI # for Authorization</div> <div>SELECT... ▼</div>	
<div>Type of Care</div> <div>DETOK</div>	<div>Authorized User</div> <div></div>

ended for additional clinical review.



the next screen.  
and it will go to a clinical representative 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



Subscriber Name



Type of Request

**INITIAL**

Submission Date

**05/06/2021**

Level of Care

**PSYCHOSOCIAL REHABILITATION**

Type of Care

**DETOX**

NPI # for Authorization

**N/A**

Mod 3	Mod 4	Service Class	Description
		SOP	STRUCTURED OUTPATIENT

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

Vendor ID		Save Request as Draft
<div></div>		NPI # for Authorization
		SELECT...
REHAB	Type of Care <b>DETOX</b>	Authorized User
		<div></div>
Attending Physician		
<div></div>		
Utilization Review Contact		
<div></div>		

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

<a href="#">Description</a>	
<a href="#">on</a>	
<a href="#">on</a>	

on

on

diagnosis code and description.

on

on

on

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  
requently than hourly.

edical team? ☐ Yes ☐ No

☐ [Preparation](#)

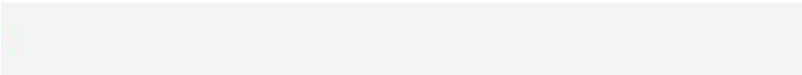
Social supports engaged in active substance use ☐ Social isolation

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

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

	<a href="#">Dimension 3</a>
ns and Complications:	Emotional, Behavioral, or Cognitive Conditions
2 <input type="radio"/> 3 <input type="radio"/> 4	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
	<a href="#">Dimension 6</a>
Use, or Continued Problem Potential: <i>le to detoxification.</i>	Recovery/Living Environment: <i>N/A is only applicable to detoxification.</i>
2 <input type="radio"/> 3 <input type="radio"/> 4A <input type="radio"/> 4B <input type="radio"/> N/A	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4A <input type="radio"/> 4B <input type="radio"/>





[Enter or Review Referrals](#)

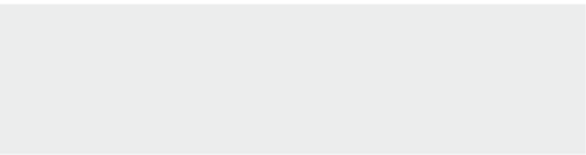
- [Review Referrals](#)

[Enter Bed Tracking Information](#)

[Search Beds/Openings](#)

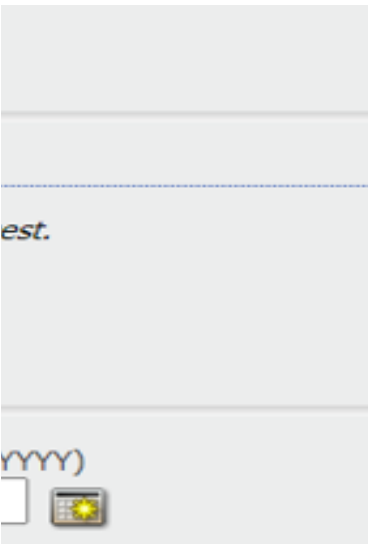
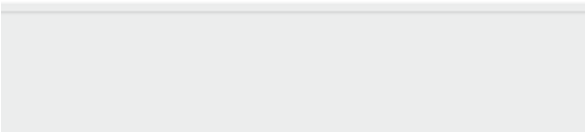
[View My Recent Authorization Letters](#)

ProviderConnect allows you to accomplish an array of daily tra



---

**06/17/2020**



or ID

of Birth (MMDDYYYY)

nt

[Redacted]

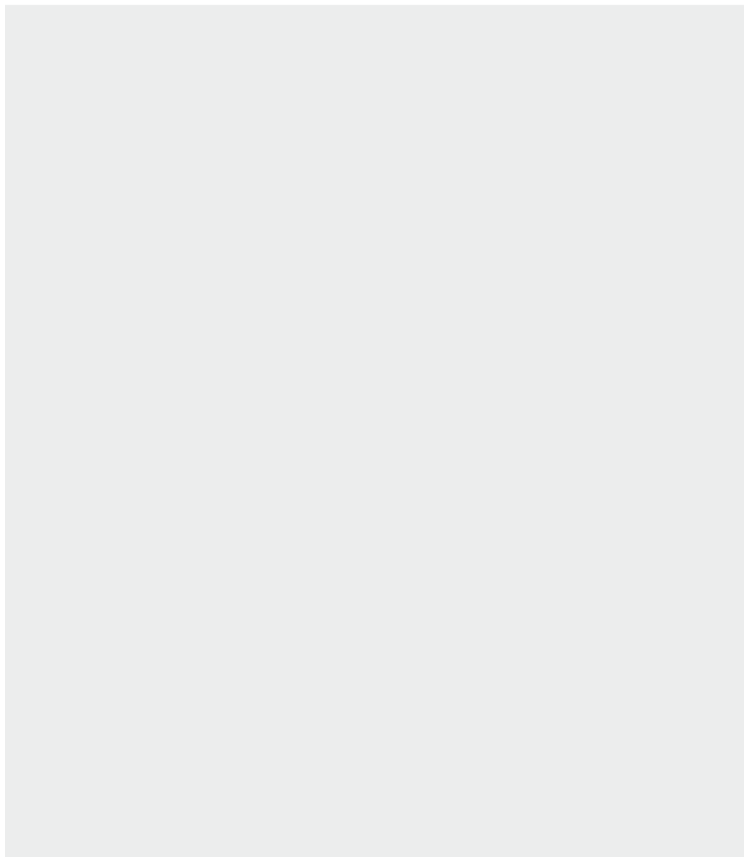
▼

Phone #

Ext

Phone #				Ext	
Phone #				Ext	
Fax					

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





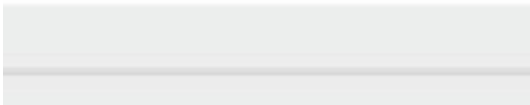
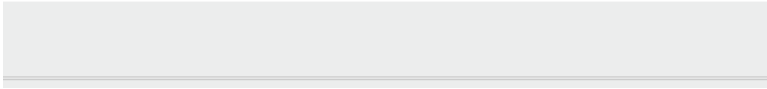
- ☐ Problems related to the social environment
- ☐ Homelessness
- ☐ Medical disabilities that impact diagnosis or must be accommodated for in treatment

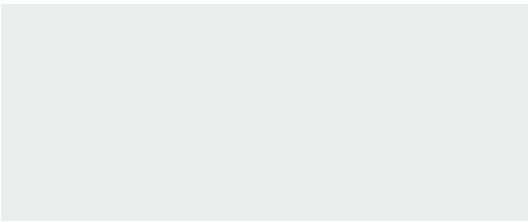
ent Score

ions

☐ High

☐ High





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

ProviderConnect Home

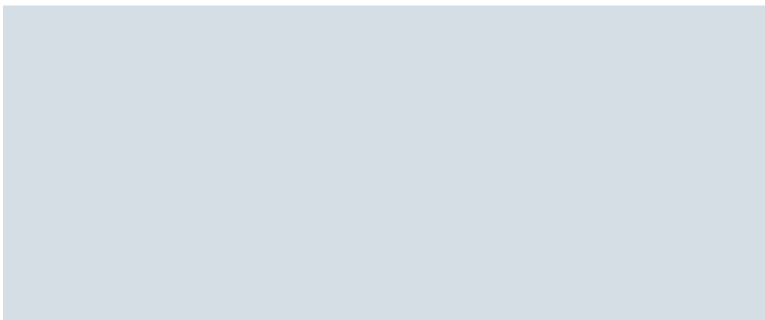
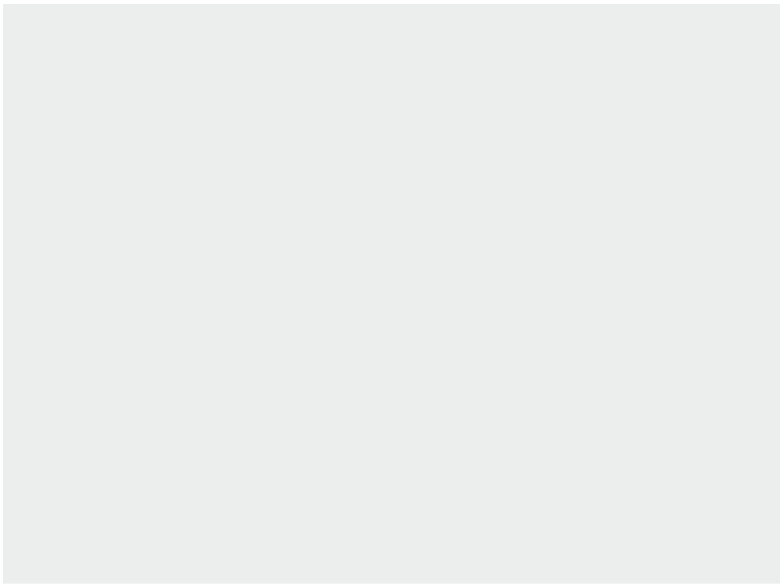
Subscriber ID

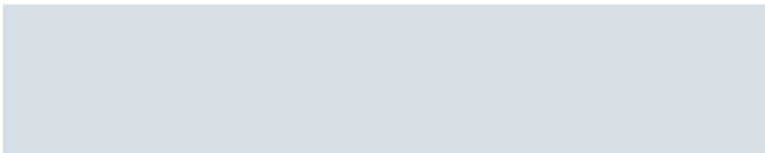
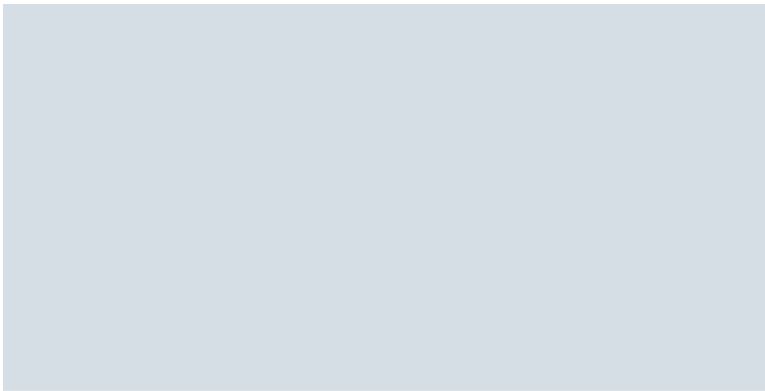
on

	Visits Requested/Approved
PATIENT/IOP	4/ 4
4	
4	

[illegible]

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





<hr/>	
4A and 4B. N/A is only applicable to detoxification.	
and Complications:	
follows the actual ASAM assessment	
<input type="radio"/>	N/A

