

Provider Connect - Main Menu

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

Provider CONNECT
STAGING BEACON HEALTH OPTIONS

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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 Thank you for using our system

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](#)
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 - [Weekly Behavior Analysis Measures](#)
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CLINICAL SUPPORT TOOLS

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

Beacon Health Options is continually striving to increase the quality of care we provide. We ask that you agree to abide by all privacy, HIPAA, and other government regulations.

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"/> (MMDDYYYY)

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Member Demographics

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



Demographics **Enrollment History** **COB** **Additional Information** **P**

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

Member?

Member ID

Alternate ID

Member Name

Date of Birth

Address

Alternate Address

Marital Status

5

Home Phone

Work Phone

Relationship

1

Gender

M - Male

Member Participates in Message Center Communication with Providers? **No****Next****View Spectrum Record****Di**

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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

These fields prefill based on what was entered on the pr

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

This se

*Document Type:

Does this Document contain clinic

*Document Description

SELECT...

Upload File *Click to attach a doc*

Attached Document:

Back

Next

Notification Form - Initial Request

Requested Services Header

Requested Start Date
05/06/2021

Member Name

Provider Name

Type of Request
INITIAL

Member ID

Provider ID

Level of Service
INPATIENT/HLOC

Type of Service
SUBSTANCE USE

Level of Care
PSYCHOSOCIAL

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

Note - Only one of these c

Admitting Physician

Phone #

Ext

Preparer	Phone #	Ext
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary Care Coordination

PCP Contacted Status

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

O
a

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

* [Diagnosis Code](#)

Additional Behavioral Diagnosis

Diagnostic Category 2

[Diagnosis Code](#)

Diagnostic Category 3

[Diagnosis Code](#)

Diagnostic Category 4

[Diagnosis Code](#)

Diagnostic Category 5

[Diagnosis Code](#)

Primary Medical Diagnosis

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

* Diagnostic Category 1

[Diagnosis Code](#)

Diagnostic Category 1 is a required field, You can



Diagnostic Category 2	<input type="text" value="SELECT..."/>	<input type="text" value="Diagnosis Code"/>
Diagnostic Category 3	<input type="text" value="SELECT..."/>	<input type="text" value="Diagnosis Code"/>

Social Elements Impacting Diagnosis

* Check all that apply

<input type="checkbox"/> None	<input type="checkbox"/> Problems with access to health care services
<input type="checkbox"/> Educational problems	<input type="checkbox"/> Problems related to interaction w/legal system/crime
<input type="checkbox"/> Financial problems	<input type="checkbox"/> Problems with primary support group
<input type="checkbox"/> 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	<input type="text" value="SELECT..."/>	Assessment Score	<input type="text"/>																		
ASAM Criteria <table border="1"> <tr> <td><u>Dimension 1</u></td> <td>Low = member's motivation to engage in treatment and move through the stages of change</td> <td><u>Dimension 2</u></td> </tr> <tr> <td>Intoxication/Withdrawal Potential</td> <td></td> <td>Biomedic</td> </tr> <tr> <td><input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High</td> <td></td> <td><input type="radio"/> Lo</td> </tr> <tr> <td><u>Dimension 4</u></td> <td></td> <td><u>Dimension 5</u></td> </tr> <tr> <td>Readiness To Change</td> <td></td> <td>Relapse</td> </tr> <tr> <td><input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High</td> <td></td> <td><input type="radio"/> Lo</td> </tr> </table>				<u>Dimension 1</u>	Low = member's motivation to engage in treatment and move through the stages of change	<u>Dimension 2</u>	Intoxication/Withdrawal Potential		Biomedic	<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High		<input type="radio"/> Lo	<u>Dimension 4</u>		<u>Dimension 5</u>	Readiness To Change		Relapse	<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High		<input type="radio"/> Lo
<u>Dimension 1</u>	Low = member's motivation to engage in treatment and move through the stages of change	<u>Dimension 2</u>																			
Intoxication/Withdrawal Potential		Biomedic																			
<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High		<input type="radio"/> Lo																			
<u>Dimension 4</u>		<u>Dimension 5</u>																			
Readiness To Change		Relapse																			
<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High		<input type="radio"/> Lo																			

Projected Duration and Frequency of Treatment

Projected Date of Discharge	<input type="text"/>	<input type="button" value="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



Requested Services Header

Requested Start Date
05/06/2021

Member Name

Provider Name

Type of Request
INITIAL

Member ID

Provider ID

Level of Service
INPATIENT/HLOC

Type of Service
SUBSTANCE USE

Level of Care
PSYCHOSOC

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 be aware that if your request is above the offered number of units, it may be per

[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 show 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:	*****
Member Name	Member ID
[REDACTED]	[REDACTED]
Authorization #	Client Authorization #
[REDACTED]	N/A
Date of Admission/ Start of Services	From - To
05/06/2021	05/06/2021 - 05/10/2021
Level of Service	Type of Service
INPATIENT/HLOC	SUBSTANCE USE
Reason Code	
A83	
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 05/06/2021	Member Name [REDACTED]	Provider Name [REDACTED]
Type of Request [REDACTED]	Member ID [REDACTED]	Provider ID [REDACTED]
Level of Service INPATIENT/HLOC	Type of Service SUBSTANCE USE	Level of Care PSYCHOSOCIAL R

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

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

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

Primary Care Coordination

PCP Contacted Status

SELECT... 

PCP Contacted Name

Date Contacted



Diagnosis

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

Behavioral Diagnoses

Primary Behavioral Diagnosis

* Diagnostic Category 1

SELECT... 

* Diagnosis Code 1

[REDACTED]

* Description 1

[REDACTED]

Additional Behavioral Diagnosis

Diagnostic Category 2

SELECT... 

Diagnosis Code 2

[REDACTED]

Description 2

[REDACTED]

Diagnostic Category 3

Diagnosis Code 3

[REDACTED]

Description 3

[REDACTED]

SELECT...	<input type="text"/>	<input type="text"/>
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 diagnosis code.

* 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 withdrawal?*

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 manager
<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 medical professional?

If yes, describe: (0 of 250)

* Describe member's Current Readiness to Change

<input type="radio"/> Pre-Contemplative	<input type="radio"/> Contemplative
<input type="radio"/> Action	<input type="radio"/> Maintenance

* 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 risk.

Dimension 1	Dimension 2
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
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

▼ low

▶ high

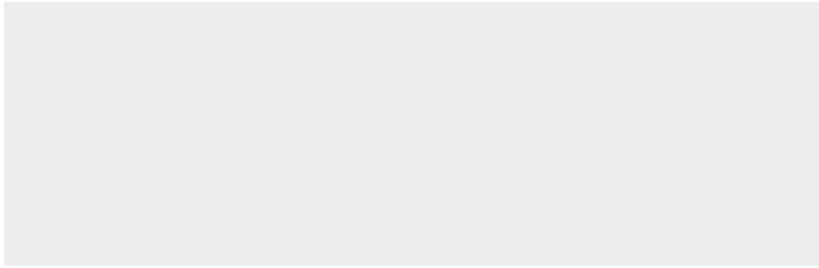
▶ low

▶ high

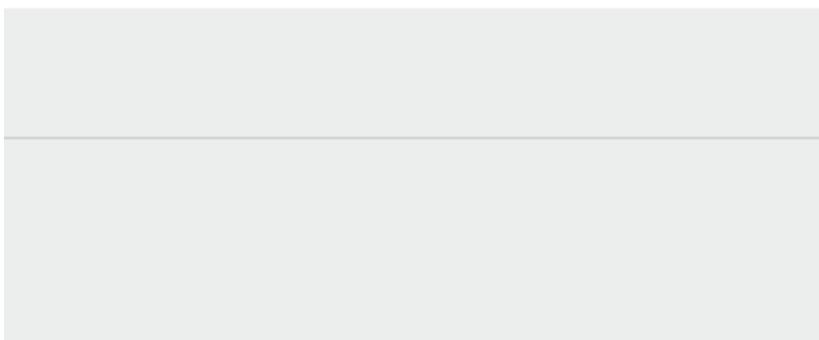


the ease in which you can interact with us by developing online communications solutions. Using I
ing laws.

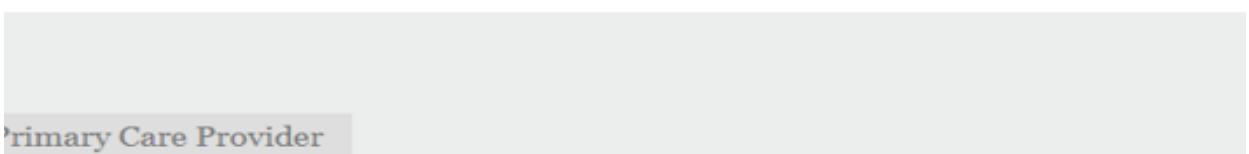




eria below.



at member information selected.



and 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 request.

Level of Service

INPATIENT/HLOC/SPECIALTY 

ICAL REHAB 

*Type of Care

DETOX 

*Admit Date (MMDD)

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.

Cal information about the Member?

Yes No



ument

Delete

Click to delete an attached document

[REDACTED]

Vendor ID

Save Request as Draft

NPI # for Authorization

SELECT...

REHAB

Type of Care
DETOX

Authorized User

Contacts needs to be filled in

Attending Physician

	Utilization Review Contact

only required if the PCP was contacted and status selected

care 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	<u>Description</u>	After entering the Code the Description will prefill
Code 2	<u>Description</u>	Blue Headers are hyperlinks with information
Code 3	<u>Description</u>	
Code 4	<u>Description</u>	
Code 5	<u>Description</u>	

select medical diagnosis code and description.

Code 1	<u>Description</u>
--------	--------------------

<u>2</u>	Description
<u>3</u>	Description

Housing problems
(Not Homelessness) [

Occupational problems [

Unknown [

Assessment score for specific tool

Secondary Assessment Measure	Assessm
SELECT...	

Dimension 2	Dimension 3
Emotional Conditions	Emot/Beh/Cogn Conditions
Low <input type="radio"/> Medium <input type="radio"/> High	Low <input type="radio"/> Medium
Dimension 5	Dimension 6
Potential	Recovery Environment
Low <input type="radio"/> Medium <input type="radio"/> High	Low <input type="radio"/> Medium

Number of Units

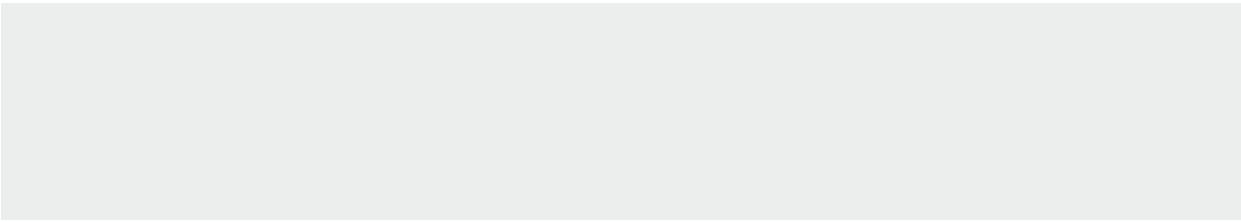
Vendor ID

NPI # for Authorization

IAL REHAB Type of Care

Authorized User

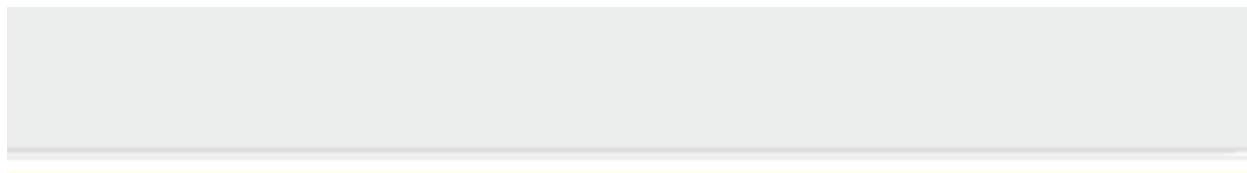
, please select "Reject" and you may enter your modified request.
ended for additional clinical review.



the next screen.

and it will go to a clinical 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

DETOK

NPI # for Authorization

N/A

Mod 3	Mod 4	Service Class	Description
50621-1-9	From 05/06/2021 To 05/10/2021	SOP	STRUCTURED OUTPA

50621-1-9 From 05/06/2021 To 05/10/2021

Authorized This Episode For 050621-1-9

DEHAB	Vendor ID [REDACTED]	Save Request as Draft
		NPI # for Authorization SELECT...
	Type of Care DETOK	Authorized User [REDACTED]
		Attending Physician [REDACTED]
		Utilization Review Contact [REDACTED]

*'be documented if necessary. Documentation of **secondary co-occurring** behavioral conditions that impact or are a factor in the delivery of services. Coverage is subject to all limits and exclusions outlined in the members plan.*

<u>Description</u> <input style="width: 200px; height: 40px; border: 1px solid black;" type="text"/>	<u>Location</u> <input style="width: 200px; height: 40px; border: 1px solid black;" type="text"/>
<u>Comments</u> <input style="width: 350px; height: 40px; border: 1px solid black;" type="text"/>	

[Redacted]

on

[Redacted]

[Redacted]

diagnosis code and description.

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

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

[Redacted]

No N/A

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

ment requires monitoring or
equent 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

	<u>Dimension 3</u>
Problems and Complications:	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
Use, or Continued Problem Potential: <i>Use to detoxification.</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
Recovery/Living Environment: <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"/> 5







[Enter or Review Referrals](#)

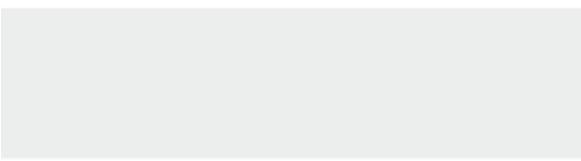
- [Review Referrals](#)

[Enter Bed Tracking Information](#)

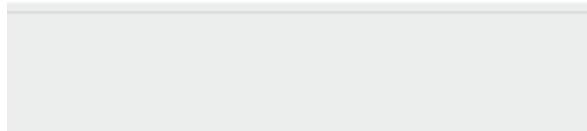
[Search Beds/Openings](#)

[View My Recent Authorization Letters](#)

ProviderConnect allows you to accomplish an array of daily tra



06/17/2020



or ID

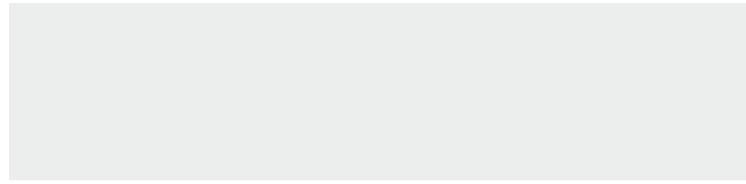
of Birth (MMDDYYYY)

11

Ext

Phone #	<input type="text"/>	<input type="text"/>	<input type="text"/>	Ext	<input type="text"/>
Phone #	<input type="text"/>	<input type="text"/>	<input type="text"/>	Ext	<input type="text"/>
Fax	<input type="text"/>	<input type="text"/>	<input type="text"/>		

*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

Patient Score

ions	
<input type="radio"/> High	
<input type="radio"/> High	

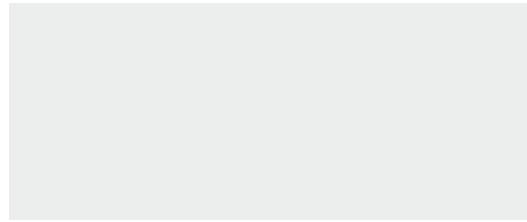
]

[REDACTED]

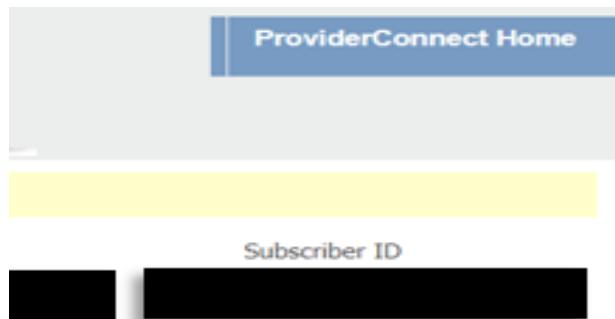
[REDACTED]

[REDACTED]

[REDACTED]



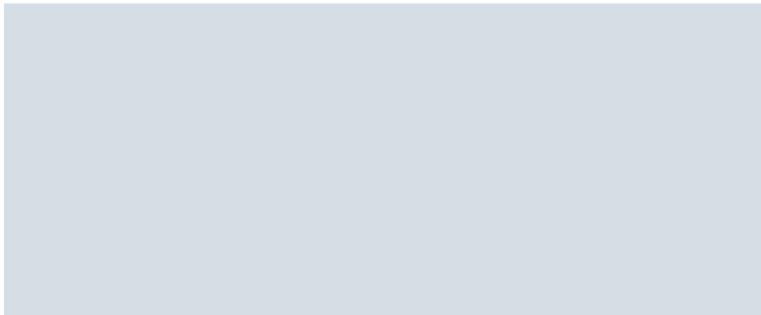
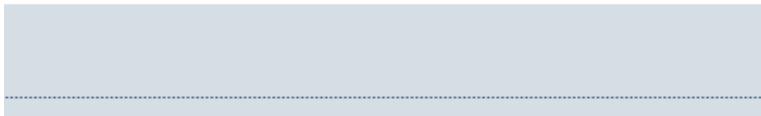
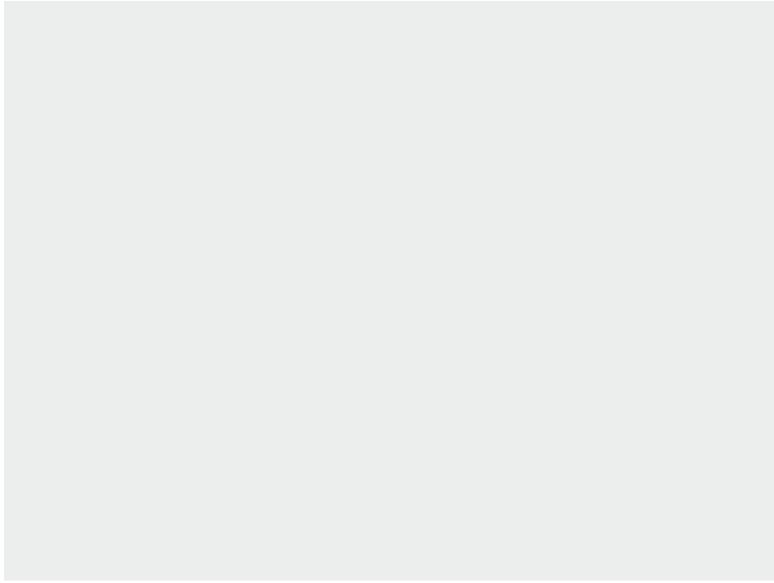
need to call and adjust the authorization prior to billing claims.

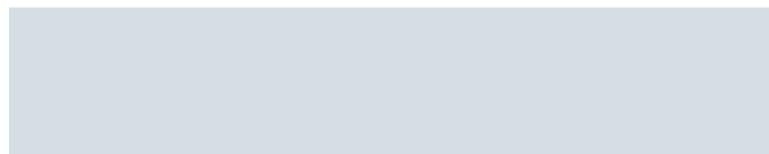
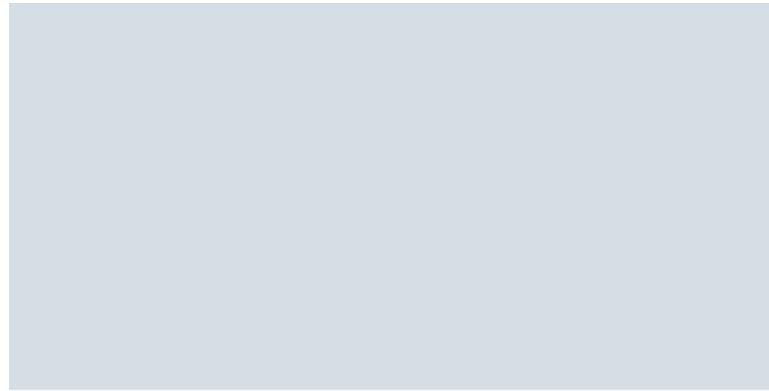


on

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

Focus 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:
.....
follows the actual ASAM assessment
.....
.....
<input type="checkbox"/> N/A

