FAXED MEMBER RELEASE OF INFORMATION, REQUEST FOR AUTHORIZATION FOR SERVICES & TRANSFER OF KCPC FILE TO A NEW PROVIDER

If all information listed below is not completed in full and submitted, this will be considered an "Incomplete Request" and Beacon Health Options will be unable to process the request. The authorization for services will be effective the date this completed fax request is received at Beacon Health Options.

PLEASE FILL OUT COMPLETELY and FAX TO 877-591-3940

Facility Information

Full Name of Your Facility ____

Complete Address ____

Contact Person ____

Phone # & Ext. # of Contact Person (_____) _____-________

Member Information

Member's Full Name ____

Member DOB ___/___/_____ **Member SSN# (if available)** ____-____-_____

Member Unique I.D. (if available) ______________________________

Level of Care Member is Entering at Your Facility:

- ☐ Level I, Individual Only
- ☐ Level I, Group Only
- ☐ Level I, Individual & Group
- ☐ Level II, Intensive Outpatient
- ☐ Case Management
- ☐ Support Services
- ☐ Level III.1 Reintegration
- ☐ Level III.2-D, Social Detox
- ☐ Level III.3 or III.5 Intermediate
- ☐ Overnight Boarding: # of Children ________
- ☐ Peer Support Services

Clinical justification for the requested Level of Care:

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Date Member started treatment at this Level of Care at your Facility ___/___/____

If the date the Member started treatment is greater than 60 days from the date of the KCPC (due to incarceration) or greater than 30 days from release of incarceration: Date of release ___/___/___

If this is a Transfer from a previous provider, did you speak with that provider to confirm that a pre-approval for the level of care was secured (if other than Social Detox) and that they have completed and forwarded the KCPC to Beacon Health Options so the file can be transferred to you? ☐ Yes ☐ No