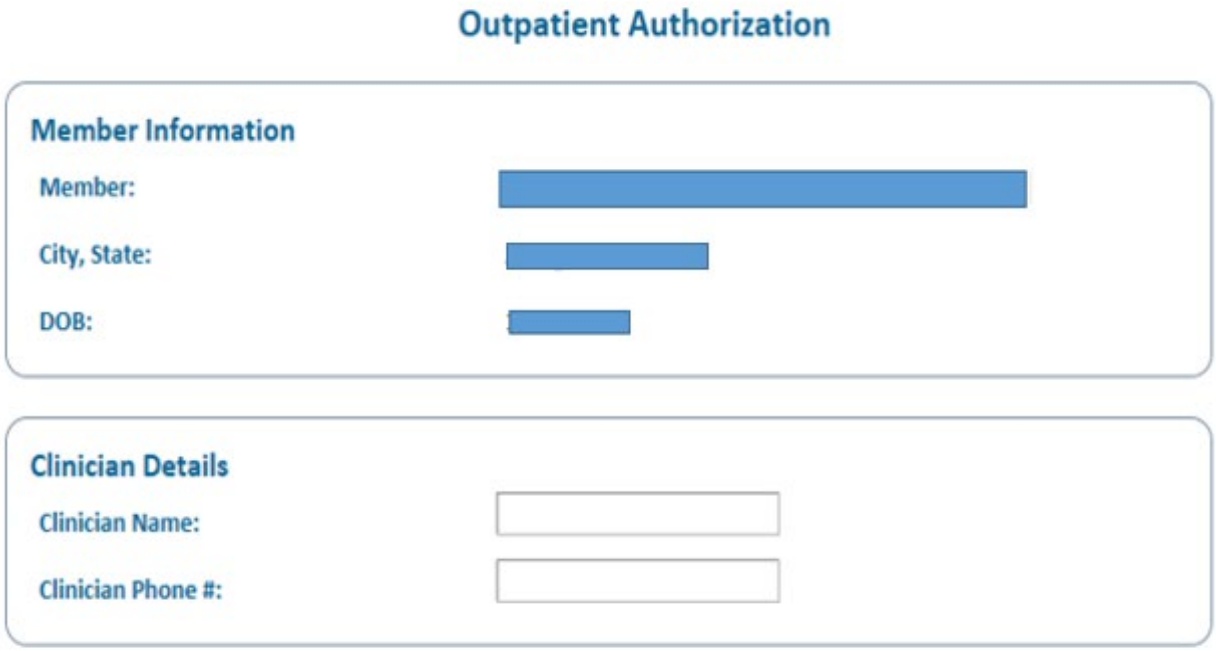
Beacon Health Options: eServices Training Guide

Outpatient Services

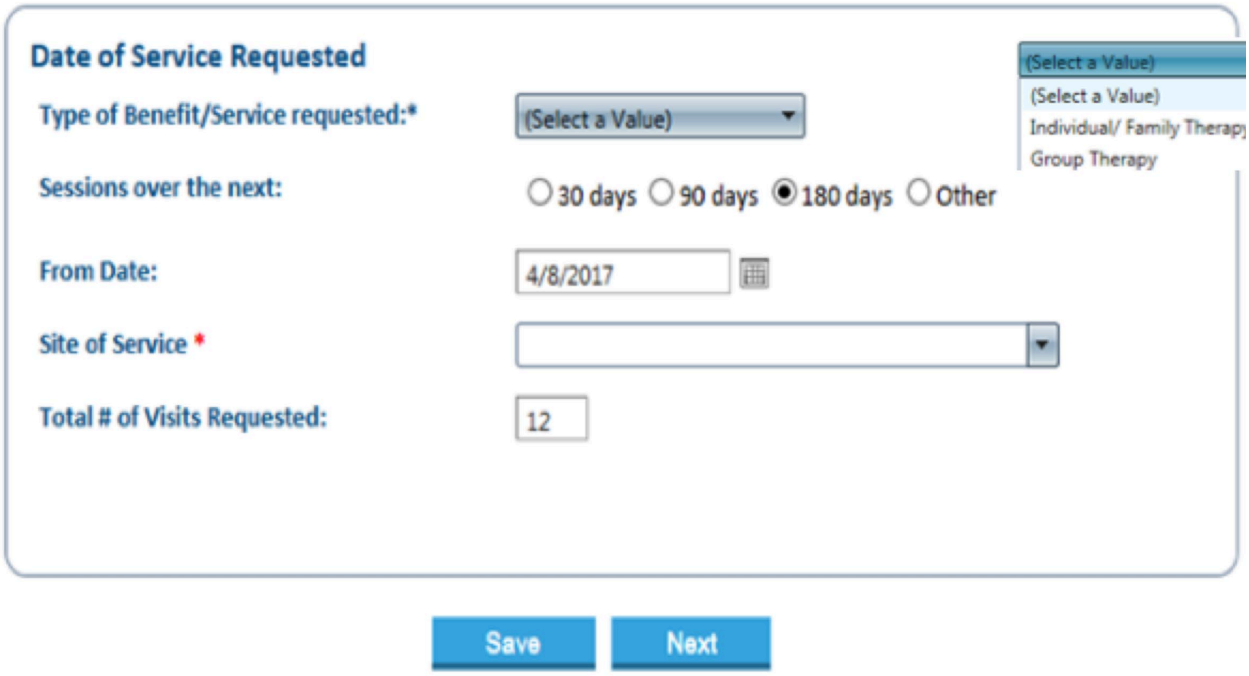


Clinician Name

Enter name of the person who will be providing the treatment.

Clinician Phone

What number can we use to contact this clinician if we have questions about this authorization request.



Type of Benefit/Service requested

Please select either Individual/Family Therapy or Group Therapy

Hint

Remember, psychiatric diagnostic/medication monitoring (90791, 90792, 99211-99215) do not require prior authorization and do not count towards initial encounters (IEs).

Sessions over the next

Select the date range you want this authorization to cover.

From date

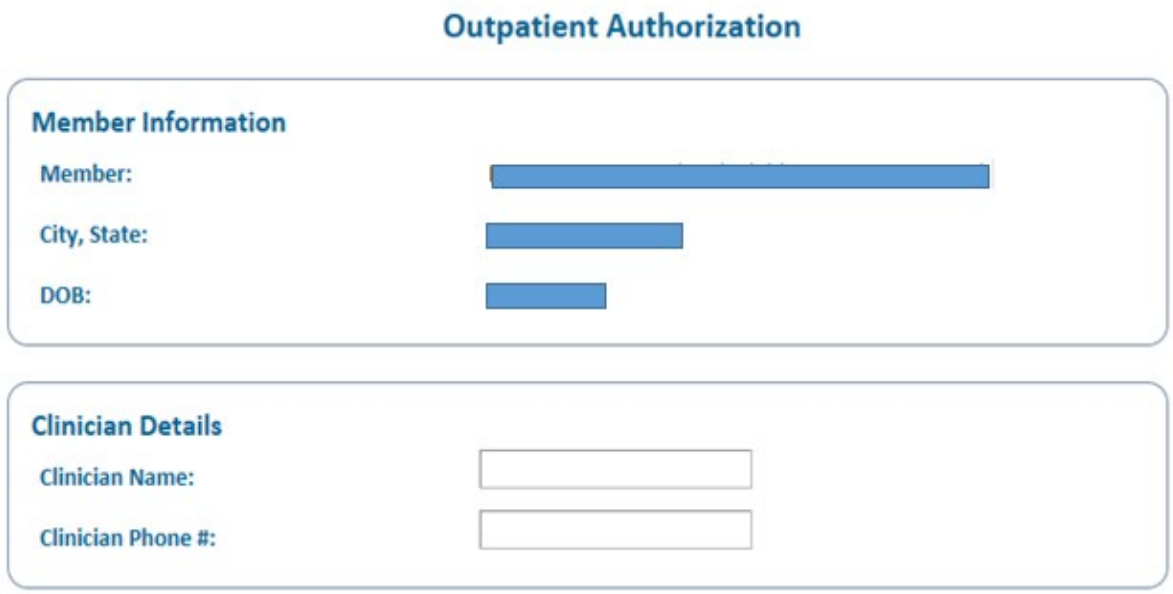
Select the date you want this authorization to begin.

Site of Service

Select the site in which treatment will be provided to the member.

Total # of Visits Requested

Please be mindful to request a reasonable number of visits.



Clinician Details

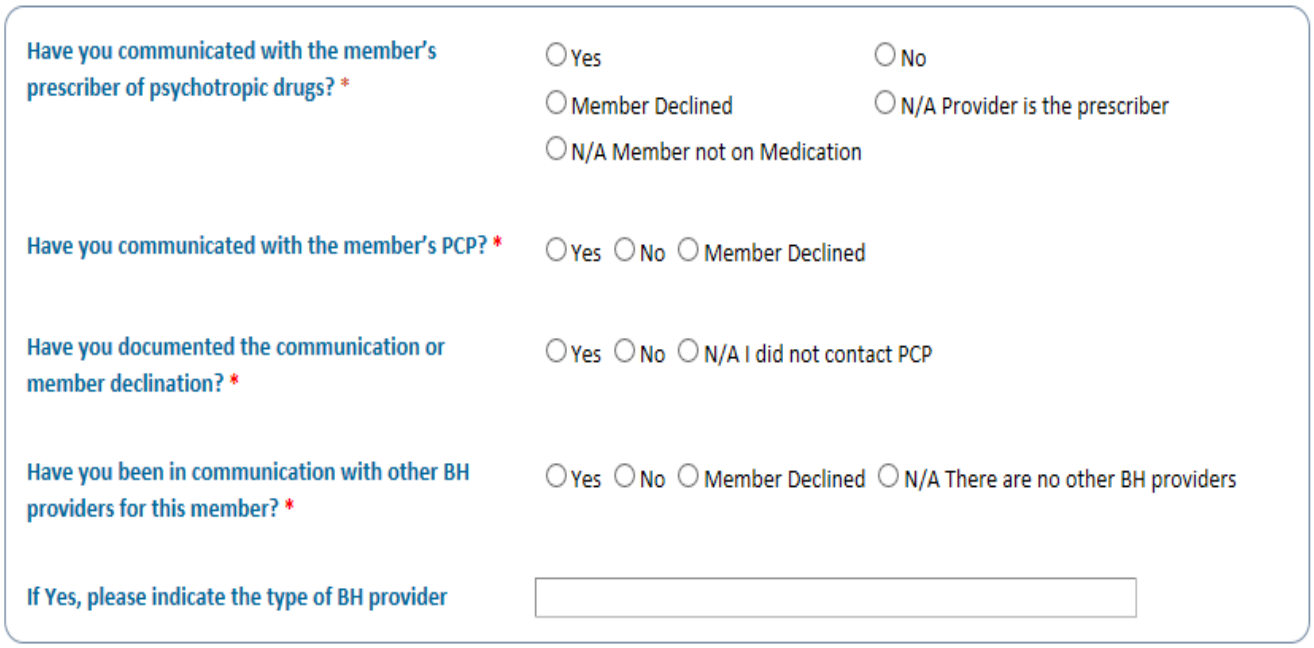
Your name and contact information.

Existing Reviews

You can ignore this field.

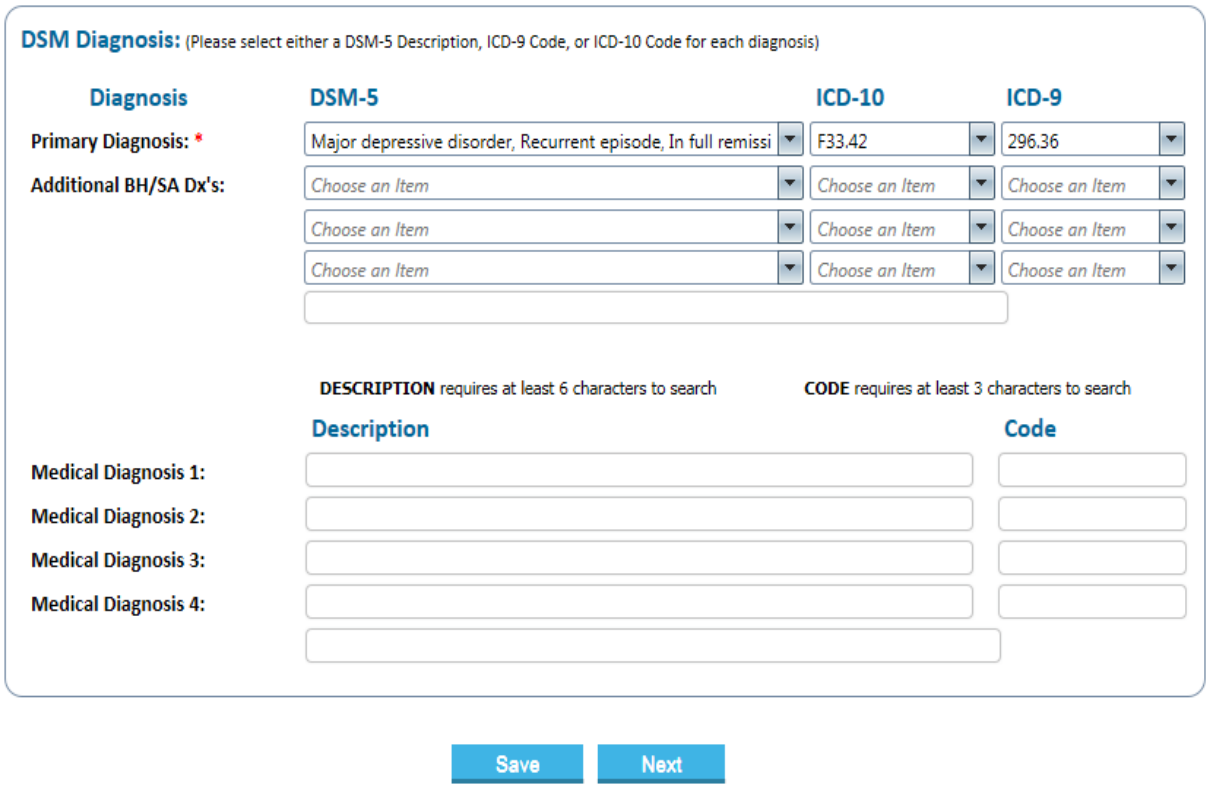
Current Psychotropic Medications

It is very important to ask member if they are currently on any psychotropic medications.



PCP/BH Provider Contact

This section is very important in completing the authorization request. Collaboration with member's PCP, Prescriber or BH provider is important to the member's continuity of care. This information is required in order to complete the authorization request. Choose the option which best describes your actions.



Primary Diagnosis

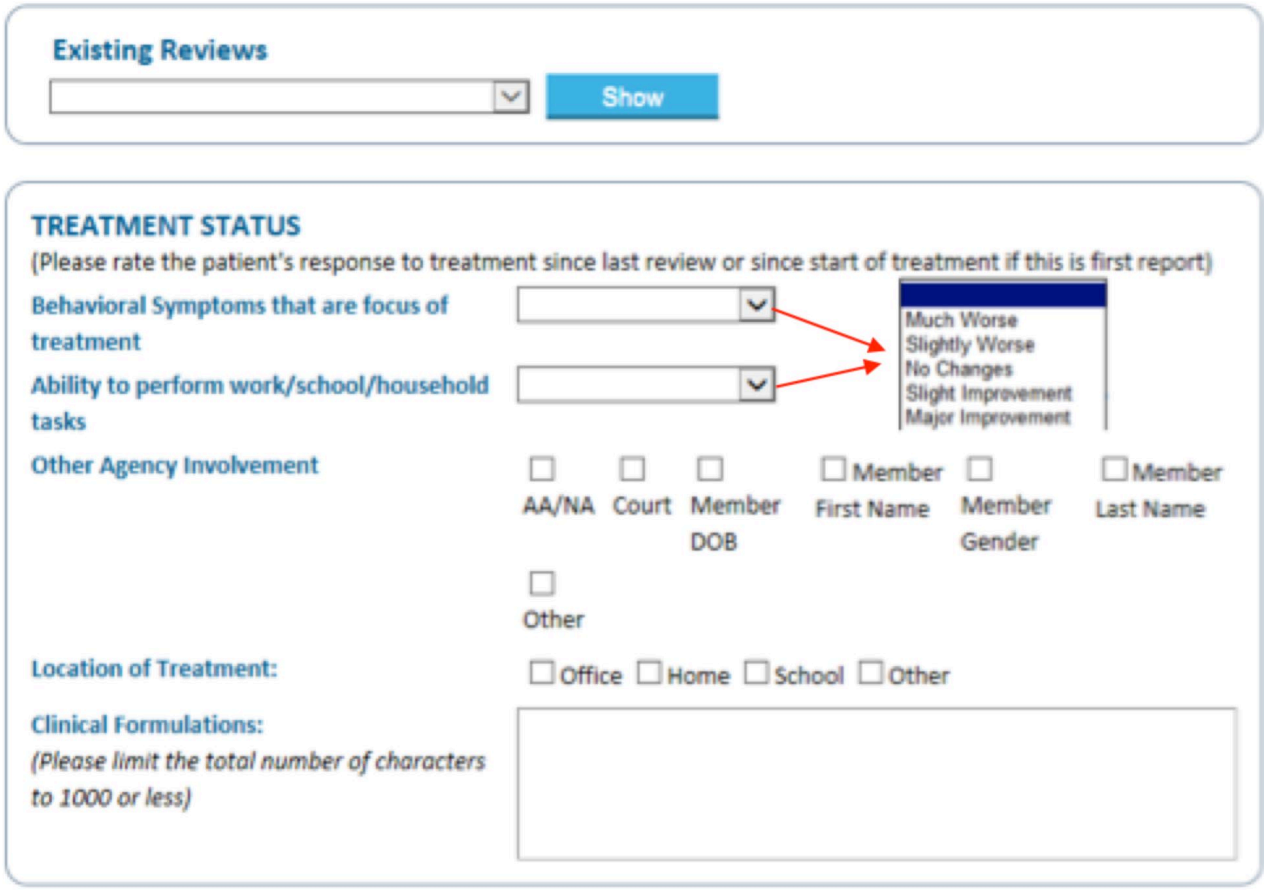
Please list all the diagnoses for this member. You can enter the first few letters of the diagnosis and the system will provide you the complete diagnosis name. You must click the “Next” button.

Hint

This screen requires that diagnosis be entered in order for you to proceed.

Hint

Once you click the “Next” button, the system will automatically enter the ICD-10 and ICD-9 codes.

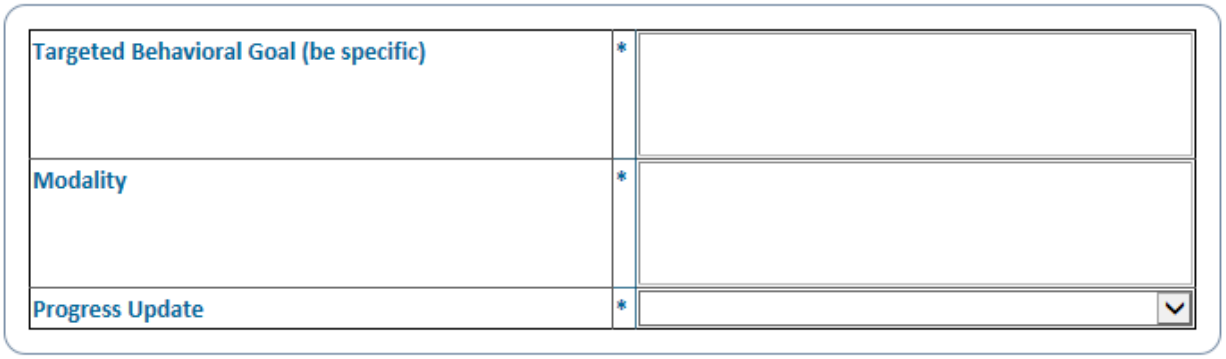


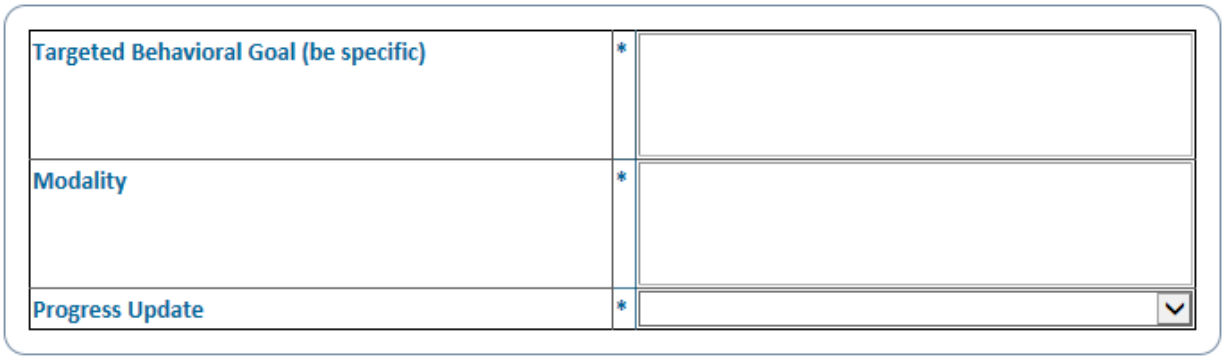
Treatment Status

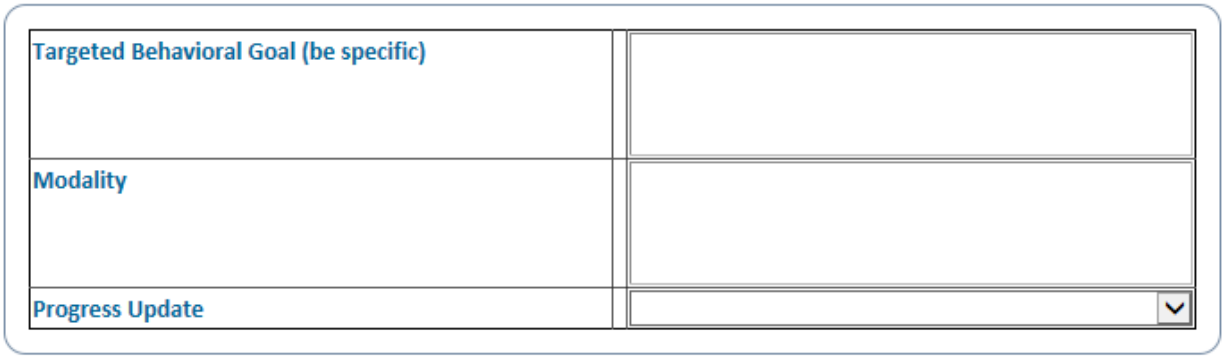
This section provides the Beacon Health Options clinician valuable information about success of treatment so far and other information needed to complete the authorization. Please provide answers to these sections if at all possible.

Clinical Formulation

Please be concise in this section. This information is extremely valuable in helping the Beacon Health Options clinician understand the trajectory of treatment.

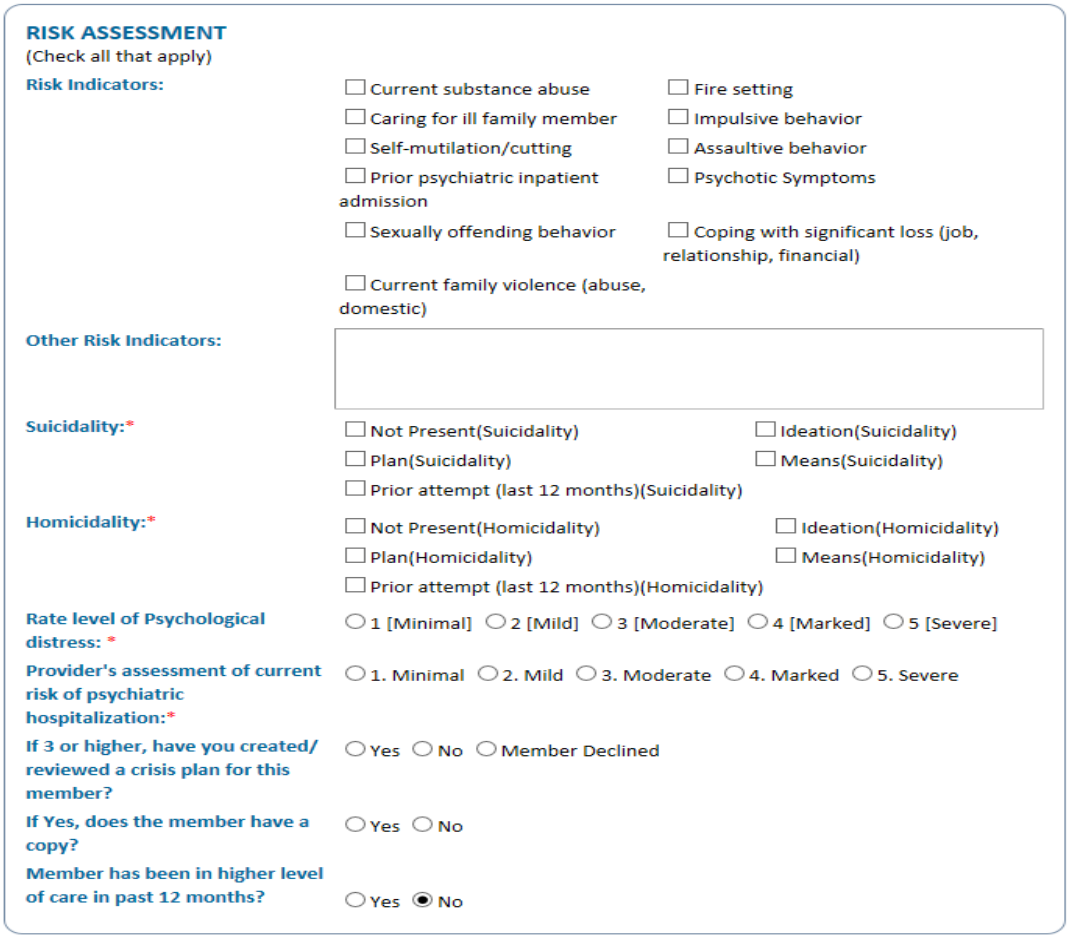






Targeted Behavioral Goals

Describe treatment goals, including specifics about what behavior(s) you are working on and what outcome(s) you are working towards. Include treatment modality and any updates regarding progress.



RISK ASSESSMENT
(Check all that apply)

Risk Indicators:

- ☐ Current substance abuse
- ☐ Caring for ill family member
- ☐ Self-mutilation/cutting
- ☐ Prior psychiatric inpatient admission
- ☐ Sexually offending behavior
- ☐ Current family violence (abuse, domestic)
- ☐ Fire setting
- ☐ Impulsive behavior
- ☐ Assaultive behavior
- ☐ Psychotic Symptoms
- ☐ Coping with significant loss (job, relationship, financial)

Other Risk Indicators:

Suicidality:*

- ☐ Not Present(Suicidality)
- ☐ Plan(Suicidality)
- ☐ Prior attempt (last 12 months)(Suicidality)
- ☐ Ideation(Suicidality)
- ☐ Means(Suicidality)

Homicidality:*

- ☐ Not Present(Homicidality)
- ☐ Plan(Homicidality)
- ☐ Prior attempt (last 12 months)(Homicidality)
- ☐ Ideation(Homicidality)
- ☐ Means(Homicidality)

Rate level of Psychological distress: *
○ 1 [Minimal] ○ 2 [Mild] ○ 3 [Moderate] ○ 4 [Marked] ○ 5 [Severe]

Provider's assessment of current risk of psychiatric hospitalization:*
○ 1. Minimal ○ 2. Mild ○ 3. Moderate ○ 4. Marked ○ 5. Severe

If 3 or higher, have you created/ reviewed a crisis plan for this member?
○ Yes ○ No ○ Member Declined

If Yes, does the member have a copy?
○ Yes ○ No

Member has been in higher level of care in past 12 months?
○ Yes ◉ No

Risk Assessment

Please complete this section in its entirety. Several of these sections require a response.

Risk Indicators

Current risk indicators for the member.

Suicidality / Homicidality

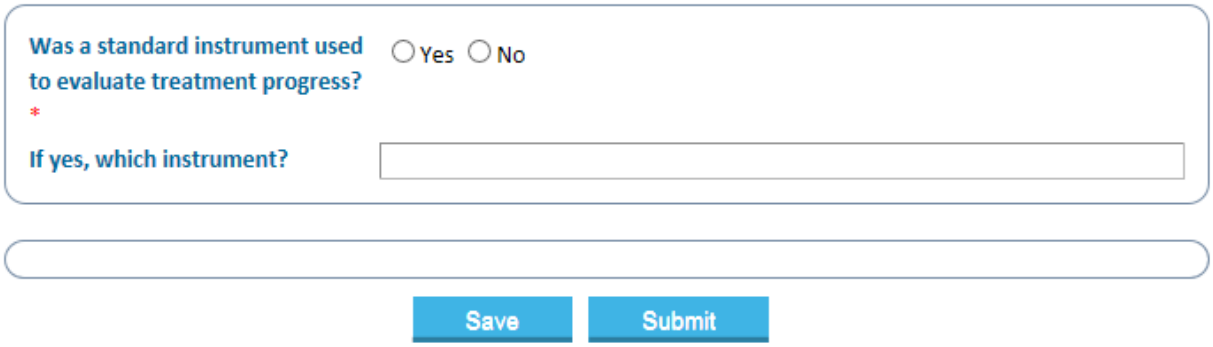
Please answer these sections.

Risk Level of Psychological Distress

Please answer this section.

Risk Level of Psychiatric Hospitalization

Please answer this section and the corresponding questions.



Standard Instrument and Evaluation of Treatment Progress

Please answer this section and list any instruments used to determine if progress was made in treatment

Submit

Once complete please click “Submit”. Your request for authorization of outpatient services will be reviewed by a Beacon Health Options clinician. You can check on eServices after at least three business days to see if your request for authorization was approved.