Beacon Health Options Colorado—Substance Use Disorder
Initial Authorization Request for Outpatient SUD Treatment

All fields are required. If you are **faxing** your request, you must **use this form**. Submit **one** form for each member. **Fax only one member at a time**. If you are using **Provider Connect**, you are not required to upload this form for **initial authorization** requests. **However, if a member has been discharged from treatment and re-admitted, please upload this form including the discharge date**. **Your request will be processed within 10 days of receipt. We only retroactively authorize 30 days from the date of receipt**. Please fax to Beacon Health Options at 719.538.1439. Should you have questions, call us at 800.804.5008 option 3.

Provider Name:	
Beacon Health Options Provider ID:	
Provider Billing Tax ID:	
Servicing Address:	
Provider contact number, fax, and email address for follow up questions:	

Enter member information and diagnosis code for member's treatment. Enter the procedure code, one per line. Enter the start date and time and number of units per code. If member was discharged from treatment prior to the current request, enter the date and time of discharge. We **must** know if the member signed the 42 CFR Part 2 Release of Information—this is **mandatory**.

Member Name	Colorado Medicaid ID#	DOB	42 CFR Part 2 Signed? Yes or No	Primary Diagnosis Code (IDC-10)	Procedure Code(s)	Start Date and Time	Discharge Date and Time	Number of Units Requested