California Counties ~ Beacon Health Options, Inc.

Fax Authorization Requests for Out of County Medi-CAL

Fax Line: **855-524-6067**

Form Must be **Filled Out In Its Entirety** to be Processed

(PLEASE PRINT LEGIBLY)

Requestor's Name: ____ Phone#: (___ _)______________________

Fax#: (____ _)________________________________ **(fax # to return this authorization form back to)**

Provider Name: _______________________________________ Phone#: (______)_______________________

Address where services are rendered to Member:____

City: ____________________________ State: _______ Zip: __________

County where services are rendered to Member: __________________________________

Member Name: _____________________________ DOB: _____/_____/_____

Address where Member is now living: ____

City: ____________________________ State: _______ Zip: __________

County of Origin (Host): _______________________________

SSN: ________-_____-___________ Medi-Cal #:

Placement: Foster Care / Group Home / Adoptive Home / Relative Care/ OTHER:_________

Gender: M / F Ethnicity: ______________________________

Authorization Start Date Requested: _____/_____/_____

Type of Auth**: New / Concurrent**

Type of Service: Assessment only/Outpatient Therapy / Medication Mngt / Psychological-Testing / Case Conference

Special Notes:

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For Internal Use Only:

Eligibility Verified ____________ Home County: _________________________________

****If county of origin is San Bernardino verify the required clinical form is attached before authorizing****

Auth Number: _______-_____________-________-________

Type: ________ # of Sessions: _____ Effective Date: ____/____/____ Exp Date: ____/____/____ CM/CSA: __________

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