FACILITY LOCATIONS AND SERVICES FORM (LSF)

Complete one form per service location (copy as needed)

Site Name: ______________________________

Address Line 1: ______________________________

Address Line 2: ______________________________

City, State, ZIP: ______________________________

Phone Number: ______________________________

Site Medicare Number: ______________________________

Site Medicaid Number: ______________________________

Site NPI Number: ______________________________

BILLING ADDRESS: (Please confer with your Billing Dept.)

Tax ID Number: ______________________________

Payable To: ______________________________

Address Line 1: ______________________________

Address Line 2: ______________________________

City, State, ZIP: ______________________________

This Location is:

Americans with Disabilities Act Compliant ___Yes ___ No

Accessible by Public Transportation ___Yes ___ No

PLEASE COMPLETE BELOW BASED ON THE BEHAVIORAL HEALTH SERVICES OFFERED AT THE SITE.

FACILITY SERVICES	TOTAL # BEDS	CHILD 0-12	ADOL 13-17	ADULT 18-64	GERI 65+	NOTES/ RESTRICTIONS
INPATIENT PSYCHIATRIC						
INPATIENT (ACUTE) DETOXIFICATION						
INPATIENT SUBSTANCE USE REHAB						
INPATIENT DUAL DIAGNOSIS						
INPATIENT EATING DISORDER						
RESIDENTIAL TREATMENT (MH)						
RESIDENTIAL TREATMENT (SUD)						
RESIDENTIAL TREATMENT (DUAL DIAGNOSIS)						
RESIDENTIAL TREATMENT EATING DISORDER						
PARTIAL HOSPITALIZATION (MH)						
PARTIAL HOSPITALIZATION (SUD)						
PARTIAL HOSPITAL (DUAL DIAGNOSIS)						
PARTIAL HOSPITAL EATING DISORDER						
DAY TREATMENT (MH)						
DAY TREATMENT (SUD)						
DAY TREATMENT (DUAL DIAGNOSIS)						
DAY TREATMENT EATING DISORDER						
INTENSIVE OUTPATIENT (MH)						
INTENSIVE OUTPATIENT (SUD)						
INTENSIVE OUTPATIENT (DUAL DIAGNOSIS)						
INTENSIVE OUTPATIENT EATING DISORDER						
AMBULATORY DETOX / OUTPATIENT—MEDICALLY SUPERVISED WITHDRAWAL						
COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAM (CPEP)						

SUBSTANCE USE TREATMENT SERVICES	SERVICE: YES/NO	# DAYS PER WEEK	AGE RANGE	NOTES/ RESTRICTIONS
METHADONE MEDICATION AND DISPENSING			TO	
SUBOXONE MEDICATION AND DISPENSING			TO	
VIVITROL (INJECTABLE NALTREXONE)			TO	
PHYSICIAN VISIT IN AN SUD FACILITY			TO	
MEDICATION MONITORING—MAT IN AN SUD FACILITY			TO	

SPECIALTY SERVICES	AGE RANGE	NOTES/RESTRICTIONS
23-HOUR OBSERVATION BED	TO	
HALFWAY HOUSE	TO	
HOME HEALTH CARE—PSYCH RN	TO	
HOME HEALTH CARE—AIDE	TO	
CRISIS/EVALUATION IN ER	TO	
CRISIS STABILIZATION	TO	
CRISIS INTERVENTION	TO	
INPATIENT ECT	TO	
MOBILE CRISIS	TO	
TREATMENT GROUP HOME	TO	

OUTPATIENT SERVICES	AGE RANGE	NOTES/RESTRICTIONS
OUTPATIENT CLINIC (MH) (OUTPATIENT FEE SCHEULE)	TO	
OUTPATIENT CLINIC (SUD)	TO	
OUTPATIENT CLINIC (DUAL DIAGNOSIS)	TO	
EAP—EMPLOYEE ASSISTANCE PROGRAM	TO	
ABA—APPLIED BEHAVIOR ANALYSIS	TO	
TELEHEALTH (MH)	TO	
TELEHEALTH (SUD)	TO	

MISCELLANEOUS SERVICES	AGE RANGE	NOTES/RESTRICTIONS
ASSERTIVE COMMUNITY TREATMENT (ACT)	TO	
CASE MANAGEMENT FOR SERIOUSLY & PERSISTENTLY MENTALLY ILL	TO	
COMMUNITY INTEGRATION COUNSELING	TO	
COMPREHENSIVE MEDICAID CASE MANAGEMENT	TO	
CONTINUING DAY TREATMENT	TO	
MOBILE MENTAL HEALTH CARE	TO	
PEER-DELIVERED SERVICES	TO	

FACILITY LOCATIONS AND SERVICES FORM (LSF)

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MISCELLANEOUS SERVICES	AGE RANGE	NOTES/RESTRICTIONS
PEER MONITORING	TO	
POSITIVE BEHAVIORAL INTERVENTIONS AND SUPPORTS (PBIS)	TO	
STRUCTURED DAY PROGRAM	TO	

OTHER SERVICES	TOTAL # BEDS	CHILD 0-12	ADOL 13-17	ADULT 18-64	GERI 65+	NOTES/RESTRICTIONS

The listing of a service above does not guarantee that the service will be covered under every health plan. To be reimbursed, a service provided to a member must be a covered benefit under the member's health plan and the member must be eligible for coverage on the date of service.

Attestation Statement:

I hereby attest that the location listed above is licensed to render the services indicated herein. I also attest that the information provided in this document is true, accurate and complete to the best of my knowledge as of this date and I understand that falsification, omission, or concealment of material fact may subject me to rejection or termination as a network provider, in addition to any administrative, civil or criminal penalties provided by law. I further agree to inform promptly Beacon Health Options, Inc., Beacon Health Strategies LLC and/or its affiliate(s) of all material changes to the information I have provided.

Name: ______________________________ Title: ______________________

Signature: ____________________________ Date: ______________________