Leave of Absence/ Practice is Full Form Statement

I, _____ am submitting the following request to Beacon Health Options:
Provider Name (First, Middle Initial, Last)

☐ Practice is Full

or

☐ Leave of Absence (Out of Office) Reason (select from drop down list) Maternity/Paternity

This will be effective _____ to _____.
Effective Date Expiration Date

Identification Information:

NPI: _____ Tax ID: _____ Beacon Provider ID: _____

Service Location Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____Fax Number:_____

Email Address: _____

Do you have additional service locations? No If yes, please complete the second page of this form.

During this timeframe, I will not be able to continue active treatment of Beacon's members, accept new referrals and/or offer an appointment.

Failure to contact Beacon within thirty (30) days of return may result in referral, utilization management and claims processing delays due to the 'inactive' status placed on the file.

Applicable for Leave of Absence Only
I understand, failure to notify Beacon or respond to communication related to 'inactive' or out of office status may result in termination of participation in Beacon's provider networks.

Disclaimer / Instructions for CAQH Providers Only
I understand I should update my CAQH profile to reflect my Leave of Absence or Practice is Full status prior to submitting this form. If I fail to do so, I am aware that CAQH will overwrite any submitted requests I send to Beacon Health Options.

Provider (Business Owner)Signature: _____

Signature Date: _____

Instructions: Sign, print and fax form to 866-612-7795

beacon
health options

Leave of Absence/ Practice is Full Form Additional Service Locations

Provider Name: _____
(First, Middle Initial, Last)

Service Location #2

Address: _____

City:_____ State: _____ Zip Code: _____

Service Location #3

Address: _____

City:_____ State: _____ Zip Code: _____

Service Location #4

Address: _____

City:_____ State: _____ Zip Code: _____

Service Location #5

Address: _____

City:_____ State: _____ Zip Code: _____

Instructions: Complete, print and fax form to 866-612-7795 together with the signed first page