Out of Network Pre-Authorization Form

This form must be completed and on file prior to a patient admission for substance abuse or mental health treatment.

beat it! Employee Assistance Programs

Mail or fax completed form to:

Address: **Beat It! Employee Assistance Programs**
20079 Stone Oak Parkway, Ste. 1105-158
San Antonio, TX 78258

Fax: 800.828.3939

Part 1: General Information	
Review Type: ☐ Non-Urgent. ☐ Urgent	Clinical reason for urgency
Request Type: ☐ Initial ☐ Extension/Renewal	(if extension) Previous Authorization Code

Part 2: Patient Information		
Last Name	First Name	MI
Daytime Phone	Date of Birth	Sex: ☐ M ☐ F ☐ Other
Subscriber Name (if different)	SSN or Medical ID	

Part 3: Provider Information		
Provider or Facility Name	NPI #	
Phone	Fax	Email
Primary Care Provider/Lead Counselor	Phone (if different from above)	

Part 4: Services Requested (with CPT, CDT or HCPCS Codes & Supporting ICD diagnosis)				
Planned Services/Procedures	Code	Start Date	End Date	ICD-10 Diagnosis
☐ Residential ☐ Intensive Outpatient ☐ Outpatient Individual				

Part 5: Clinical Documentation

1. Provide a brief narrative of the necessity in this space or in an attached statement.
2. Attach supporting clinical documentation.

Part 6: Requesting Provider Signatures

Date	Print Name of Primary Care Provider/Lead Counselor

☐ Signature of Primary Care Provider/Lead Counselor

My signature above indicates that I have made the patient/subscriber fully aware that this admission may only be authorized as an out-of-network admission in lieu of a Network or Single Case Agreement. Any potential payment from the health plan will be in accordance with the plan's Summary Plan Document. The patient/subscriber understands that they may be responsible for any or all costs not covered by the plan.

I also understand and acknowledge that Beat It! Is not a claims payor and that final claims payment is at the discretion of the health plan.

FOR THIS FORM TO BE VALID, IT MUST ACCOMPANY THE UNDERSTANDING MY FINANCIAL RESPONSIBILITY FORM (SIGNED BY THE PATIENT/SUBSCRIBER) TO ENSURE THE PATIENT HAS BEEN FULLY INFORMED OF THEIR POTENTIAL FINANCIAL RESPONSIBILITY.

Part 7: Authorization / Denial (to be completed by Beat It! Employee Assistance Programs

Authorization Type: ☐Approved ☐Denied	Authorization Code	Through Date

Reason for Denial

Signature of Beat It! Representative