# MEDICATION MANAGEMENT REGISTRATION FORM

Prescribers need to complete this form when requesting Medication Management only

For most efficient and timely service – use of authorization request flow on ProviderConnect® is the preferred method of submitting requests. Faxed or mailed forms should only be submitted to the specific fax or address. Please confirm for a specific contract that forms are allowed. Some contracts allow only telephonic review if web service is not utilized. Some contracts require that requests only be submitted via the web. Some contracts do not require authorization for medication management services.

If other outpatient services are being requested, please complete the Outpatient Review Form as appropriate.

PLEASE TYPE OR PRINT LEGIBLY. Check/circle response where applicable.

Request Start Date __/__/____

Type of Service Requested: Mental Health Substance Abuse

**Patient Name** ________________________________________

Date of Birth: _________________Age: ________________ M F

Address: (City/State only): ________________________ Tel. #________

Patient's Insurance ID#: _______________________________________

Patient's Employer/Benefit Plan: ________________________________

**Provider Name:** _____________________________________________

Provider: Program/Clinic: (if applicable)

VO Provider # (if known) ____________________________________

Service Address: ___________________________________________

City/State/ZIP: _____________________________________________

Is this also your mailing address? Yes No If not, please update below signature.

Are you independently licensed to provide services in the State where you are treating this patient? Yes No

ID# ____________________ Check Which: SSN TaxID NPI

**Diagnosis:**

Behavioral DX (ICD code & Description): 1.____________/______________

2.____________/______________ 3.____________/______________

Medical DX (ICD Code & Category: 1.____________/______________

2.____________/______________ 3.____________/______________

Social Elements Impacting DX: 1.__________________ 2.______________

Optional Functional Assessment: Tool: ______________ Score:___________

Additional Info:___________________________________________________

**Requested Services:**

Medication Management M0064 Wkly: Mnthly: Qtrly: Other:_______

Other:____________________ Wkly: Mnthly: Qtrly: Other:_______

Other:____________________ Wkly: Mnthly: Qtrly: Other:_______

**Treating Provider's Signature**:______________________________

Date:_________________________

Updated Mailing Address:__________________________________

City/State/Zip:____________________________________________

Beacon revised 12/15/15