



BEACON HEALTH OPTIONS (VALOP) PRE-ENROLLMENT INSTRUCTIONS

WHICH FORM(S) SHOULD I DO?

- **ProviderConnect Online Services Account Request Form**
- **Online Provider Services Intermediary Authorization Form**
- **Availity EDI Enrollment Form**

WHERE SHOULD I SEND THE FORM(S)?

- Fax the **Providerconnect** and **Online Provider Services** forms to (866) 698-6032
- Email the **Availity EDI Enrollment Form** to Support@officeally.com
 - *Please note this form should be sent after the payer's enrollment forms have been completed.*

WHAT IS THE TURNAROUND TIME?

- Standard processing time is approximately 1 week.

HOW DO I CHECK STATUS?

- To check your enrollment status, reach out to Beacon Health Options' EDI Helpdesk at (888) 247-9311.



ProviderConnect Online Services Account Request Form

Special Setup:

Additional User Account

Super User Account

Military OneSource

Horizon Behavioral Health

Provider, Practice or Facility Name

Beacon Health Options Assigned ID

National Provider Identifier (NPI)

Provider, Practice or Facility Tax IDs to be associated to this online account. If more than one, please list all.

Address

City State Zip Code

(____) _____ (____) _____
Telephone Number Fax Number

Please check which Online Provider Services options you are requesting:

- Electronic Batch Claims (837) 277CA Acknowledgement File
- Direct Claims Submission 999 Acknowledgement File

Automatically included:

✓ Eligibility Inquiry

✓ Claim Status

✓ Authorization Inquiry

✓ Provider Summary Vouchers

Provider has retained a 3rd party Billing Agent or Clearinghouse to submit claims on their behalf. Yes No
(Other than office staff) (If yes, please complete the Billing Intermediary Authorization Form)

Depending on the state in which you are practicing, you may need multiple logins created to ensure the claims are processed accurately (i.e. Medicaid vs. Commercial). If you intend to submit **batch** transactions for one of the states below please mark the appropriate box:

- | | | | |
|--|------------------------------|-----------------------------|-------------------------------|
| Colorado, batch claims for Colorado Medicaid clients? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Both |
| Kansas, batch claims for Kansas Medicaid or AAPS Block Grant clients? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Both |
| Maryland, batch claims Maryland BHA clients? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Both |
| Massachusetts, batch claims for Massachusetts Behavioral Health Partnership (MBHP)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Both |
| Pennsylvania, batch claims for SWPA Medicaid clients? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Both |
| Pennsylvania, batch claims for Non-HealthChoices Mental Health Program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Both |
| Texas, batch claims for Texas NorthSTAR clients? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Both |
| Illinois, batch registration for Illinois Mental Health Collaborative or ICG clients? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Georgia, batch registration, authorization, discharge or claims for Georgia Collaborative ASO? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

Contact Name (ProviderConnect Account User)

Contact's e-mail address

E-mail address where you would like to receive your batch submission file feedback



Agreement Terms:

- A. The undersigned submitter authorizes Beacon Health Options, Inc. to receive and process claims or batch registration, authorization and/or discharge submissions via the Beacon Health Options Electronic Transport System (ETS) or Beacon Health Options Online Provider Services Program on his/her/its behalf in accordance with the applicable regulations.
B. All submitted information must be true, accurate and complete. I/We understand that payment of any claim submitted in falsification or concealment of a material fact may be prosecuted under any applicable state and/or federal laws.
C. The Submitter agrees to comply with any laws, rules and regulations governing the Beacon Health Options Online Provider Services/EDI program.
D. The Provider agrees to accept, as payment in full, the amounts paid in accordance with the fee schedules provided for under previously established agreements with Beacon Health Options.
E. This is to certify that an exact copy of any claim files submitted via the Beacon Health Options ETS system or Online Provider Services program will be stored in an electronic medium and held by the originator for a period of 90 days or until the submission has been finalized as to reimbursement or denial of payment, whichever comes first.

This is to certify that the following is true:

___ I am a provider
OR
___ I am office staff of a Provider, and am authorized to sign on their behalf.

Signatures:

Legal name of Organization Title of individual signing for organization
Name of Individual Signing for Organization Authorizing Signature Date

For Super User Accounts Only; Managed User Information:
First and Last Name of Initial Managed User (Must differ from Contact Name on page 1) Managed User's Phone
Managed User's e-mail address (Please print) (Must differ from Contact Email on page 1)

Incomplete, incorrect or illegible forms may delay or prevent proper processing



Instructions for Account Request Form

The Account Request Form is only for activating online access on Beacon Health Options ProviderConnect website. If you need to update your address, tax ID or NPI information, you will need to contact our Provider Relations area at 800.397.1630. Please do not make additional notations on the Account Request Form unless advised to do so by these instructions or by the EDI Helpdesk.

For guides on Direct Claim Submission and Authorization Submission, visit the Compliance page at: <http://www.valueoptions.com/providers/ProCompliance.htm>.

Additional User Account:

If a ProviderConnect account already exists for the provider or facility, and an office staff member needs their own unique ID/password, you can check this box. If this secondary account needs to be disabled or deleted for any reason, it will be the provider's responsibility to contact the EDI Helpdesk immediately.

Super User Account:

Only check this box if you are registering to access ProviderConnect as an administrator to manage other users of your account.

Provider ID number:

You can retrieve your Beacon Health Options assigned provider number by reviewing any Provider Summary Vouchers/EOBs you have previously received; the Provider # will be present at the beginning of each claim. Or, depending on what state and type of claims you will be submitting, the following service centers will be able to best assist you:

For all commercial accounts or states not listed below: 800.397.1630

Colorado Medicaid: 800.397.1630

Illinois Mental Health Collaborative or ICG: 800.397.1630

Kansas Medicaid or AAPS Block Grant: 800.397.1630

Maryland DHA: 800.888.1965

Massachusetts MBHP: 800.495.0086 (If submitting for both Commercial and MBHP clients, please provide both provider numbers)

Pennsylvania SWPA Medicaid or Non-HealthChoices Mental Health Program: 800.397.1630

Texas NorthSTAR: 800.397.1630

Georgia Collaborative: 800.397.1630

Batch vs. Direct Claim Submission:

Direct Claim Submission: If you are a smaller practice, or happen to have a low volume of Professional claims (normally submitted on a HCFA-1500 or CMS-1500), Single Claim Submission may be best and easiest. With this option, you can submit each claim directly on the website, the member and provider information are verified, and you receive a claim number right away.

Batch Claim Submission: If you have to submit Institutional claims (submitted on a UB-92 or UB-04 form), and/or if you have a larger volume of Professional Claims, you can select Batch Claim submission. With this feature, you will create your claims using either our EDI Claims Link Software, or any practice management software that can create an 837 HIPAA file. You will then upload a batch file via our website for processing. Claim numbers are usually available in about 1 business day. All new accounts are set up in test mode. A successful test batch must be submitted, and the EDI Helpdesk contacted to switch to production mode.

Claim Adjustment: The ProviderConnect Online Adjustment Module allows users to electronically submit changes (adjustments) to previously processed claims. This feature allows users to correct claims where the original result of the claim's processing is not the correct outcome for the services rendered or where information was submitted incorrectly on the original claim.

Commercial and Medicaid Claims:

We may need to create more than one online account for you if you need to submit both commercial and Medicaid claims.

If you only select commercial or Medicaid for now, and you need to add the other in the future, please contact the EDI Helpdesk and we can make the appropriate updates for you. **If no option is checked, the default will be Commercial Only.**



Online Provider Services Intermediary Authorization Form

Purpose: This form should be completed by providers who contract with a third party to submit claims. If the Billing Intermediary will submit claims for multiple providers, an Account Request Form and an Intermediary Authorization Form is required for each provider. All fields must be completed.

Billing Agent/Clearinghouse / Intermediary Information:

Provider Information:

Availity Corporation

Billing Intermediary Name

Provider Name

AV01101957

Billing Intermediary's Submitter ID (if already established)

Provider NPI Number

Payer Enrollment

Contact Name at Billing Intermediary

Provider Tax ID

aacenrollment@availity.com

Email Address at Billing Intermediary

Beacon Health Options Assigned Provider ID

(800) 282-4548

Phone Number at Billing Intermediary

Please check those options for which you have been authorized by the below-signed provider.

- Batch Claim Submission & Claim Adjustment (837 HIPAA)
Direct Claim Submission & Claim Adjustment (ProviderConnectSM)

Automatically included:

- Eligibility Inquiry
Claim Status
Authorization Inquiry
Provider Summary Vouchers

Agreement Terms:

- A. The undersigned Provider authorizes the above Billing Intermediary to submit claims to Beacon Health Options, Inc. (Beacon) on his / her / its behalf in accordance with any applicable regulations.
B. The provider warrants that he / she / it has entered into a written agreement with above named Billing Intermediary. The provider understands and agrees that its use of this Billing Intermediary does not in any manner relieve the provider of full responsibility and liability for any violations of the laws, regulations and rules which govern the Beacon EDI program.
C. The provider accepts full liability for all actions of the above named Billing Intermediary within its actual or apparent authority to act on behalf of the provider, notwithstanding any contrary provisions in the agreement between the provider and the Billing Intermediary. In the case of any violations of applicable laws, rules and regulations governing the Beacon EDI program, which arise out of the actions of the Billing Intermediary, the provider accepts full liability as though these actions were the provider's own actions.
D. The provider agrees to notify Beacon in writing at least ten (10) days prior to the effective date of the revocation of this Intermediary Authorization Form. In such event, the provider's liability for the acts of the Billing Intermediary will continue until the tenth day after the receipt of such notification or the effective date of the revocation, whichever is later.

Signatures:

Yanaya McFitt, EDI Supervisor Availity
Billing Intermediary's Signature

Provider or Authorized Provider's Staff Signature

Date

Date



AVAILITY EDI ENROLLMENT FORM

Email this form to Support@officeally.com. The Email Subject should read: **Beacon Health Options EDI Enrollment**. Please make sure to print legibly and to complete this form in its entirety. You risk delaying enrollment if the application is unreadable or incomplete. All fields in **bold** are **required**.

PAYER NAME

PROVIDER INFORMATION

Provider Name:

Provider Address:

City:

State:

Zip:

PROVIDER IDENTIFIERS INFORMATION

**Provider Federal Tax Identification Number
Employer Identification Number (EIN):**

National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION

Contact Name:

Telephone Number/Extension:

Email Address:

Fax Number:

SUBMISSION INFORMATION

Reason for Submission:

Date Payer Enrollment Submitted:

Authorized Signature:

Note: Electronic Signature (Typed Name) of Person Submitting ERA Enrollment.