



WHICH FORM(S) SHOULD I DO?

- **Online Provider Services Account Request Form**
- **Online Provider Services Intermediary Authorization Form**
 - The owner or other authorized personnel may sign the forms
- If you wish to receive **Electronic Remittance Advice (ERA)**, you must create an account (free) with [PaySpan Health](#)
 - **Note:** Office Ally cannot supply or access these reports. You will **not** be able to access your ERAs through your Office Ally account
- If you wish to receive **Claim Status Reports (aka Summary Vouchers)**, you must create an account with Value Options using the following instructions:
 - Go to www.valueoptions.com
 - Select the Provider Tab
 - Select Register under Provider Connect login on the right hand side of the screen
 - Call (888) 247-9311 option 2 for help
 - It is important to include your email address on this form since your password will be sent to this email address.
 - If you do not create the account for Claim Status Reports, you risk having a rejected claim and being unaware of it. Office Ally has no way of accessing/supplying these reports

WHERE SHOULD I SEND THE FORM(S)?

- Fax the forms to Value Options at (866) 698-6032

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 1 week

HOW DO I CHECK STATUS?

- One week after faxing your form to Value Options, you must call (888) 247-9311 option 2 and ask if your account has been set up and linked to Office Ally.
- Once Value Options verifies that you have been linked to Office Ally, you **MUST** call Office Ally at (360) 975-7000 option 1 and inform them of the approval **PRIOR** to submitting claims electronically.



Online Provider Services
Account Request Form

Required fields are marked with an asterisk. *
Fax pages 1 & 2 of completed form to 866-698-6032.
Questions on this form? Read instructions on page 3.

Special Setup: (See page 3)
[] Additional Login Account
[] Super User Account
[] New Combined Account
[] Existing Combined Account:
Login ID: _____

*Provider, Practice or Facility Name

*ValueOptions assigned Provider ID. If not known, please see page 3

*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 would like to have access to:

- [] Electronic Batch Claims Submission (837 HIPAA format)
[] Direct Claims Submission
[] Military OneSource Case Activity Form
[] Horizon Behavioral Health Authorizations

Automatically included:
[X] Eligibility Inquiry [X] Claim Status Inquiry
[X] Authorization Inquiry & Submission
[X] Provider Summary Vouchers/EOBs

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 accounts created to ensure the claims are processed accurately (i.e. Medicaid vs. Commercial). Therefore, to help us in setting up your account(s) correctly, if you are located in...

- Colorado, will you be submitting CO Medicaid clients? [] Yes [] No, Commercial Only [] Both
Kansas, will you be submitting either KS Medicaid Claims or AAPS Block Grant clients? [] Yes [] No, Commercial Only [] Both
Maryland, will you be submitting MD MHA clients? [] Yes [] No, Commercial Only [] Both
Massachusetts, will you be submitting MBHP clients? [] Yes [] No, Commercial Only [] Both
Pennsylvania, will you be submitting SWPA Medicaid clients? [] Yes [] No, Commercial Only [] Both
Pennsylvania, will you be submitting for the Non-HealthChoices Mental Health Program? [] Yes [] No Counties: _____
Texas, will you be submitting TX NorthSTAR clients? [] Yes [] No, Commercial Only [] Both

Illinois, will you be submitting Batch Registration Files for Illinois Mental Health Collaborative or ICG clients? [] Yes [] No

@
*Provider's Contact e-mail address - Please print

@
E-mail address where you would like to receive your batch submission file feedback. - Please print.

*Contact Name at Provider's Office



Online Provider Services
Account Request Form

Required fields are marked with an asterisk. *
Fax pages 1 & 2 of completed form to 866-698-6032.
Questions on this form? Read instructions on page 3.

Agreement Terms:

- A. The undersigned submitter authorizes ValueOptions to receive and process claims or batch registration submissions via the ValueOptions Electronic Transport System (ETS) or ValueOptions 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 ValueOptions 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 ValueOptions.
- E. This is to certify that an exact copy of any claim files submitted via the ValueOptions 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:	
_____ *First and Last Name of Initial Managed User	_____ *Managed Users Phone
_____@_____ * Managed Users e-mail address – Please print	



Instructions for Account Request Form

The Account Request Form is only for activating online access on ValueOptions ProviderConnect website. If you need to update your address, tax ID or NPI information, you will need to contact our ProviderRelations 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 Login 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.

New Combined Account:

Only check this box if you are registering multiple provider numbers, you want them accessible from a single user ID and password, and if you currently do not have a login ID for ProviderConnect. In the area for Provider Number, you can write "See Attached List," and include an additional list containing the provider's name, ValueOptions provider #, NPI, and tax ID. This information must be complete and accurate.

Existing Combined Account:

Only check this box if you currently have a Combined account login ID for ProviderConnect, and you want to include an additional provider number to be accessible from this account. Please write your existing login ID on the blank line. Make sure you put the new provider number in the appropriate field, or send a list as described above.

Provider ID number:

You can retrieve your ValueOptions 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 MHA: 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

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

Required fields are marked with an asterisk. *
Please fax completed form to 866-698-6032.
Questions on this form? Call 888-247-9311

INSTRUCTIONS:

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. Forms that are incomplete, incorrect or illegible may delay or prevent proper processing.

Billing Agent/Clearinghouse/Intermediary Information

Provider Information:

Office Ally, LLC

*Provider Name

*Billing Intermediary Name

*Provider NPI number

OFFICEALMD

*Provider NPI number

*Billing Intermediary's Submitter ID (if already established)

*ValueOptions assigned provider ID number

Customer Service

*ValueOptions assigned provider ID number

*Contact name at billing intermediary

*ValueOptions assigned provider ID number

support@officeally.com

*Email address at billing intermediary

360-975-7000 Option 1

*Phone number at intermediary

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

- Electronic Batch Claims Submission (837 HIPAA format)
Online Claims Adjustment

- Direct Online Functions:
Direct Claims Submission
Online Claims Adjustment

- Automatically included:
Eligibility Inquiry
Claim Status Inquiry
Authorization Inquiry & Submission
Provider Summary Vouchers/EOBs

Agreement Terms:

- A. The undersigned Provider authorizes the above Billing Intermediary to submit claims to ValueOptions 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 ValueOptions 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 ValueOptions 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 ValueOptions 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: [Handwritten Signature]

Brian Oneill CEO

*Billing Intermediary's Signature

*Provider or provider's staff signature

7/21/14

Date

Date