

MEDICAID MA BEHAVIORAL HEALTH (MCMAB) PRE-ENROLLMENT INSTRUCTIONS



WHAT FORM(S) SHOULD I DO?

- You must complete the 2 forms listed below:
 - Online Provider Services Account Request Form
 - Online Provider Services Intermediary Authorization Form.
- For **Electronic Remittance Advice (835/ERAs)**
 - Beacon Health Options (Value Options) uses a service called PaySpan Health to deliver Electronic Remittance Advice. If you wish to receive ERAs you must create an account (Free) on <https://www.payspanhealth.com/>.
 - If you wish to have your ERAs routed to Office Ally follow our [ERA instructions](#).

WHERE SHOULD I SEND THE FORM(S)?

- The forms should be faxed to Beacon Health Options (Value Options) at 866-698-6032.

WHAT IS THE TURNAROUND TIME FOR ENROLLMENT?

- Standard processing time is approximately 1 week.

HOW DO I CHECK STATUS?

- One week after faxing in your enrollment to Beacon Health Options (Value Options), you must call Beacon Health Options at 888-247-9311 option 2 and ask if your account has been set up and linked to Office Ally.
- Once enrollment has been approved to complete your enrollment follow instructions on the "Note to My Clients Plus Users" page and FAX info requested. We will forward to our clearinghouse and notify you by email when your registration is complete.

Note to My Clients Plus Users:

Once you have confirmed with the Insurance Payer your Billing NPI/ Provider Number is linked to Office Ally, please fax the following information to 888-653-7115.

- **Please label with “My Clients Plus” on top**
- **Provider/Practice Name as pre-enrolled with the Insurance Payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including state if BCBS, Medicare or Medicaid).**
- **The statement “I have verified my provider ID has been linked to Office Ally with the Insurance Payer”.**
- **Provider email address where you can be notified of setup completion.**
- **For EDISS or Noridian Pre-Enrollments Please Also Include:
Providers Submitter Number**

REVISED 9/29/16



ProviderConnect Online Services Account Request Form

Special Setup:
<input type="checkbox"/> Additional User Account
<input type="checkbox"/> Super User Account
<input type="checkbox"/> Military OneSource
<input type="checkbox"/> 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)
- Direct Claims Submission
- 277CA Acknowledgement File
- 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? Yes No Both
- Kansas, batch claims for Kansas Medicaid or AAPS Block Grant clients? Yes No Both
- Maryland, batch claims Maryland BHA clients? Yes No Both
- Massachusetts, batch claims for Massachusetts Behavioral Health Partnership (MBHP)? Yes No Both
- Pennsylvania, batch claims for SWPA Medicaid clients? Yes No Both
- Pennsylvania, batch claims for Non-HealthChoices Mental Health Program? Yes No Both
- Texas, batch claims for Texas NorthSTAR clients? Yes No Both
- Illinois, batch registration for Illinois Mental Health Collaborative or ICG clients? Yes No
- Georgia, batch registration, authorization, discharge or claims for Georgia Collaborative ASO? Yes 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:

Office Ally, Inc

Billing Intermediary Name

OFFICEALLY

Billing Intermediary's Submitter ID (if already established)

Customer Service

Contact Name at Billing Intermediary

support@officeally.com

Email Address at Billing Intermediary

360-975-7000 Option 1

Phone Number at Billing Intermediary

Provider Information:

Provider Name

Provider NPI Number

Provider Tax ID

Beacon Health Options Assigned Provider ID

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)

<p>Automatically included:</p> <ul style="list-style-type: none"> ✓ 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:

Billing Intermediary's Signature

11/18/16

Date

Provider or Authorized Provider's Staff Signature

Date