Provider Online Services Account Request Form

Complete this form to enroll in Electronic Data Interchange (EDI) or Direct Data Entry (DDE) Transactions with Beacon.

Provider Information

Special setup, check all that apply:
- ☐ 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

Online Services

Please check which Online Provider Services options you are requesting:

- ☐ Professional Claims (837P)
- ☐ Institutional Claims (837I)
- ☐ Direct Claims Submission
- ☐ 277CA Acknowledgement File
- ☐ 999 Acknowledgement File

Automatically included:
- **✓ Eligibility Inquiry**
- **✓ Claim Status**
- **✓ Authorization Inquiry**
- **✓ Provider Summary Vouchers**

Using a clearinghouse or intermediary? Complete Clearinghouse/Intermediary Information section below.

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. ("Both" indicates Medicaid and Commercial claims will be submitted.)

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 MHA 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
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 email address

Email address where you would like to receive your batch submission file feedback

Please return this form via fax to 866.698.6032

Beacon Health Options, Inc. | EDI Helpdesk | PO Box 1287, Latham, NY 12110 | Phone#: 888.247.9311

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

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Complete this form to enroll in Electronic Data Interchange (EDI) or Direct Data Entry (DDE) Transactions with Beacon.

Clearinghouse/Intermediary Information

To be completed only if you use a clearinghouse or intermediary. Not required for providers who submit directly to Beacon.

____
Clearinghouse/Intermediary Name

____
Address

____
City, State Zip

Reason for Submission:

_______New enrollment _______Change enrollment _______Cancel enrollment

This is to certify that the following is true:

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

Signature:

Legal name of Organization	Title of individual signing for organization

Name of Individual Signing for Organization	Authorizing Signature	Date

Your signature certifies that (i) you have the legal authority to bind the Provider named above to these Terms and Conditions; (ii) the Provider named above is bound by the Terms and Conditions; and (iii) the information concerning the Provider on this Form is true, accurate, and complete, to the best of your knowledge and belief.

For more information or to request the status of your enrollment, contact e-support.Services@beaconhealthoptions.com.

Please return this form including the Terms and Conditions via fax to 866-698-6032 or via email to e-support.Services@beaconhealthoptions.com.

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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 email address (Please print) (Must differ from Contact Email on page 1)	

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Complete this form to enroll in Electronic Data Interchange (EDI) or Direct Data Entry (DDE) Transactions with Beacon.

Provider Online Services Terms and Conditions

1. This **Provider Online Services Enrollment Form and Terms and Conditions** ("**Terms and Conditions**") address electronic transactions between the provider named above ("**Provider**") and all entities within the FHC Health Systems, Inc. corporate structure, including (but not limited to) Beacon Health Strategies LLC, Beacon Health Options, Inc. and ValueOptions of California, Inc. (individually and collectively as "**Beacon**"). The **Terms and Conditions** address the **Online Services** described above. Separate forms are available for enrolling in (i) Electronic Funds Transfers (EFTs) and (ii) Electronic Remittance Advice (ERA). See www.payspanhealth.com. Beacon may change these Terms and Conditions at any time. The most current version of the Terms and Conditions can be viewed by clicking on the link posted at https://www.beaconhealthoptions.com/providers/beacon/providerconnect/]. **By using the Online Services after we post any change, you accept the Terms and Conditions that are in effect at the time of your use.**

2. **Provider** must complete these **Terms and Conditions** to apply for access to the **Online Services** (whether or not **Provider** uses a Clearinghouse / Intermediary). ***Provider must complete a new version of these Terms and Conditions*** (i) to change any information related to **Provider's** use of the **Online Services** or (ii) to cancel **Provider's** use of the **Online Services**.

3. If **Provider** designates a Clearinghouse or Intermediary ("**Intermediary**") to conduct transactions with **Beacon** on **Provider's** behalf, **Provider** shall engage the **Intermediary** in a HIPAA-compliant business associate agreement. **Provider** is responsible for the acts and omissions of the **Intermediary** with respect to the **Online Services**, notwithstanding any contrary provisions in the agreement between **Provider** and **Intermediary**. **Provider** shall notify **Beacon** in writing at least ten (10) days prior to the effective date of **Provider's** termination of **Intermediary's** authority to act on **Provider's** behalf with respect to the **Online Services**.

4. Any user name that **Beacon** assigns to **Provider** (or a member of **Provider's** Workforce) and any password assigned to or created by **Provider** (or a member of **Provider's** Workforce) are intended to protect the privacy of **Provider** and **Provider's** patients. **Provider** is responsible for keeping all assigned user names and corresponding passwords confidential. **Provider** shall not disclose (and shall prohibit members of its Workforce from disclosing) user names and corresponding passwords to others. **Provider** shall be solely responsible for all activity or transactions that are tracked to such user names through transactions conducted pursuant to these **Terms and Conditions**.

5. **Provider** acknowledges that, by submitting information to **Beacon** in an **Online Services** transaction (either directly or through an **Intermediary**), **Provider** is responsible to ensure that the information is true, accurate, and complete and that the information is submitted for a permissible purpose under the HIPAA Privacy Rule.

6. **Provider** agrees to abide by all applicable State and Federal laws, regulations, and guidance governing access to, and use and disclosure of personally identifiable information (including Protected Health Information as defined in 45 CFR §160.103) and **Provider** understands that individuals or entities may be subject to civil and/or criminal penalties for failing to abide by such provisions.

7. **Provider** acknowledges that various State and Federal criminal provisions authorize imposition of criminal penalties, including fines and imprisonment, against individuals who, with respect to health care benefit programs, engage in conduct including, but not limited to, falsifying or concealing a material fact or making materially false, fictitious, or fraudulent statement.

8. **Provider** shall cooperate with **Beacon** in testing the transmission and processing systems used in connection with the **Online Services** as **Beacon** deems appropriate to ensure the accuracy, timeliness, completeness, and security of each data transmission.

9. Each party agrees to take all steps reasonably necessary to ensure that all electronic transactions between them conform to regulations promulgated under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 CFR Parts 160-164. **Provider** agrees to comply with the terms of the applicable Beacon Companion Guides, which are available at https://www.beaconhealthoptions.com/providers/beacon/providerconnect/.

10. **Provider** acknowledges that **Beacon** has the right to monitor electronic transactions to detect behavior that suggests improper use of the data (*e.g.*, high inquiry error rate or high ratio of eligibility inquiries to claims submitted). **Beacon** reserves the right to suspend **Provider's** use of the **Online Services** for such improper use and, when appropriate, refer **Provider** for investigation.

11. If **Provider** has signed a Participating Provider Agreement with **Beacon**, **Provider** acknowledges that all transactions exchanged through the **Online Services** are subject to that Agreement and all documents referenced therein (including but not limited to Beacon Provider Manual).

12. If **Provider** has ***not*** signed a Participating Provider Agreement with **Beacon**, **Provider** acknowledges that **Beacon** will make any applicable payment to **Provider** using Electronic Funds Transfers (EFTs) in accordance with 45 C.F.R. Pat 162. **Provider** must complete an EFT Payment Enrollment Form to be eligible for such payments. To access the EFT Payment Enrollment Form, see www.payspanhealth.com. **Beacon** reserves the right to pay a member or patient (rather than the **Provider**) for claims submitted by a non-participating provider that has not made arrangements for electronic payment of claims.

13. These **Terms and Conditions** may change from time to time. Changes will be posted at https://www.beaconhealthoptions.com/providers/beacon/providerconnect/ so that you will always be aware of the applicable **Terms and Conditions**. By using the **Online Services** after changes have been made to these **Terms and Conditions**, you agree to accept any changes. The laws of the Commonwealth of Massachusetts shall govern these **Terms and Conditions**. You agree to submit to the exclusive jurisdiction of the courts in the Commonwealth of Massachusetts and waive any jurisdictional venue or inconvenient forum objections to such court.