



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms
05/01/2012 (IE, FE)

Value Options - Massachusetts Behavioral Health (V1003)

Enrollment Instructions –Professional Claims ONLY

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm your EDI customer account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck to make sure provider ID #s are valid. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Make a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the submitted paperwork, in case you need to follow up on your request.

FAX COMPLETED FORMS TO-
Practice Insight, Enrollment Department
713-333-0138

837-CLAIMS Provider Enrollment (New)

The following forms must be completed and submitted for each billing provider.

1. Value Options Online Provider Services Account Request Form (2 pages + instruction page)
Page 1 COMPLETE all data fields with Billing Provider's information.
Page 2 OBTAIN Signature of Provider or Authorized person from Provider's office.
2. Online Provider Services Intermediary Authorization Form (1 page)
Add Provider Name, NPI #, Value Options Provider ID #, authorized signature and date.

837-CLAIMS Provider Enrollment (Change of Service)

1. Online Provider Services Intermediary Authorization Form (1 page)
Add Provider Name, NPI #, Value Options Provider ID #, authorized signature and date.

835 - ERAs Electronic Remittance Request (New) or (Change of Service)

ERA setup is available to Providers using a FREE account with PaySpan Health.
GO BACK and SEE LINK- [Value Options ERA Request](#)

ALLOW 2-4 WEEKS FOR PROCESSING

If it has been over 30 days since request was submitted and you have not yet received confirmation of enrollment, contact your reseller or software support vendor for assistance.



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
[] New Grouped Account
[] Existing Grouped Account:

*Provider, Practice or Facility Name

ValueOptions assigned Provider ID. If not known, please
contact the correct provider contacts on page 3

*NATIONAL PROVIDER IDENTIFIER # (NPI)

*Provider, Practice or Facility Tax IDs to be associated to this online account (do not include the dash)

*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 (Claim batch file uploads)
[] Direct Claims Submission (Directly on website)

Automatically included:
[X] Eligibility Inquiry [X] Claim Status Inquiry
[X] Authorization Inquiry & Submission

*Provider named above or office staff will be submitting claims [] Yes [] No (N/A if only requesting inquiry status)

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

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

Illinois, will you be submitting Illinois Mental Health Collaborative or ICG clients? [] Yes [] No, Commercial Only [] Both
If yes, will you be submitting Batch Registration Files? [] Yes [] No

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

@
* 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



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.

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 service or mailing 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.

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.

What is a Grouped Account?

- If you bill using several individual unique ValueOptions assigned provider numbers, we can set up a single login ID with access to multiple provider numbers. We will need a copy of this form for each provider, and you can check the appropriate box.
- If you bill as the facility using only a single provider ID, we only need one copy of this form. You will not need to check the “Grouped Account” box.

New Grouped 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.

Existing Grouped Account:

Only check this box if you currently have a grouped 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.

Provider ID number:

To make sure you have the correct provider ID numbers, and 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
- Pennsylvania SWPA Medicaid or Non-HealthChoices Mental Health Program: 800-397-1630
- Texas NorthSTAR: 800-397-1630

Batch vs. Single Claim Submission:

Single 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 your own practice management software. 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.

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:

*Billing Intermediary Name

*Provider Name

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

*Provider NPI number

*Contact name at billing intermediary

ValueOptions assigned provider ID number

*Email address at billing intermediary

*Phone number at intermediary

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

- Electronic Claims Submission
 Single Claims Submission
 Online Eligibility Inquiry
 Online Claim Status Inquiry
 Authorization Inquiry

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:

*Billing Intermediary's Signature

*Provider or provider's staff signature

Date

Date