ProviderConnect Account Request Form Access to Multiple Provider Files

_____
Name of staff member

_____
Address

_____ _____ _____
City State Zip Code

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

_____
Staff member's contact e-mail address – Please print

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

Please indicate if this request is for MBHP, Commercial or both. _____

☐ This is for a new login ID
☐ We are adding a provider number to an existing multi-user account. Existing Login ID: _____

Please list the names and provider number of all the providers you will need access to with this account (ProviderConnect registration for each of these providers must have been completed prior to submission of this form):

You must also indicate what specific tax IDs that this user should be allowed access to under that provider number. All fields are required. Additional sheets may be included to accommodate linking more than 5 providers at one time.

Provider/Facility Name	Beacon Health Options Assigned ID	Tax ID(s)	NPI

If you intend to submit **batch** transactions for one of the states below please mark the appropriate box:

1. Illinois, batch registration for Illinois Mental Health Collaborative or ICG clients? ☐ Yes ☐ No
2. Georgia, batch registration, authorization, discharge or claims for Georgia Collaborative ASO? ☐ Yes ☐ No

Default functions included with your account access: Eligibility Inquiry, Claim Status, Authorization Inquiry and Provider Summary Voucher access.

If you intend to submit Direct Data Entry claims via ProviderConnect please mark here: ☐ Yes ☐ No

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

Agreement Terms:

A. The undersigned submitter authorizes Beacon Health Options, Inc. to receive and process batch registration, authorization and/or discharge submissions via 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.

Signatures:

Legal name of Organization	Title of individual signing for organization

Name of Individual Signing for Organization	Authorizing Signature	Date

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