ProviderConnect Account Request Form
Access to Multiple Provider Files

_____
Name of staff member

_____
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 (837) ☐ 277CA Acknowledgement File
☐ Direct Claim Submission ☐ 999 Acknowledgement File

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

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

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

☐ 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

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:

1. Colorado, batch claims for Colorado Medicaid clients? ☐ Yes ☐ No ☐ Both
2. Kansas, batch claims for Kansas Medicaid or AAPS Block Grant clients? ☐ Yes ☐ No ☐ Both
3. Maryland, batch claims Maryland MHA clients? ☐ Yes ☐ No ☐ Both
4. Massachusetts, batch claims for Massachusetts Behavioral Health Partnership (MBHP)? ☐ Yes ☐ No ☐ Both
5. Pennsylvania, batch claims for SWPA Medicaid clients? ☐ Yes ☐ No ☐ Both
6. Pennsylvania, batch claims for Non-HealthChoices Mental Health Program? ☐ Yes ☐ No ☐ Both
7. Texas, batch claims for Texas NorthSTAR clients? ☐ Yes ☐ No ☐ Both
8. Illinois, batch registration for Illinois Mental Health Collaborative or ICG clients? ☐ Yes ☐ No
9. Georgia, batch registration, authorization, discharge or claims for Georgia Collaborative ASO? ☐ 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. (Beacon) to receive and process claims, batch registration, authorization and/or discharge submissions via the Beacon Electronic Transport System (ETS) or Beacon 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 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.

E. This is to certify that an exact copy of any claim files submitted via the Beacon 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.

Signatures:

Legal name of Organization	Title of individual signing for organization	
Name of Individual Signing for Organization	Authorizing Signature	Date

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