



ProviderConnect User Guide

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Revision History

Click on the link for the revision that you want. Although every effort is made to keep the links current, users should consult the Table of Contents if a particular link does not work. Note that the revision history encompasses a maximum of three years.

Last Revised Date	Revised By	Revisions
01/17	L. Finta	Updates from 12/16/16 release: <ul style="list-style-type: none"> New Warn and Restrict Access to ProviderConnect When Attestation Is Due chapter added New Invalidate a Service Location section added to Chapter 23, Update Demographic Information
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Introduction

ProviderConnect Overview

ProviderConnect is an easy-to-use online application that providers can use to complete everyday service requests. Providers have the ability to access information 24 hours a day/7 days a week.

Providers can use ProviderConnect to:

- Obtain information about member eligibility and benefit status
- Enter authorization/notification requests
- Search claims and authorizations
- View and print correspondence
- Access and update practice profiles
- Submit EDI claims and inquiries to the Beacon Customer Service Department
- Send messages to and receive messages from Beacon
- Send messages to and receive messages from members
- Attach documents

In addition, ProviderConnect contains links to other resources such as:

- Compliance
- Provider Handbook
- Forms
- Network Specific Information

User Guide Overview

After reading this guide, users will be able to:



- Understand the basic navigational system flow
- Access and register a provider
- Search member information
- Search claims
- Enter an authorization/notification request
- Enter a claim
- Update a provider profile
- Verify eligibility and benefit status
- Submit an EDI claim
- Obtain applicable forms

Contact Information

If you have any questions or need further clarification about the subject matter, please contact National IT Training at ITtrainingrequests@beaconhealthoptions.com or visit the [Learning and Development](#) page on Navigator.

Before You Begin

Before using this guide please take note of the following:

- A  graphic showing in the margin signifies a freestanding user note.
- Important things to remember are indicated with a  symbol.
- Hyperlinks look like this: [Sample Link](#)
- **Things like button, field, checkbox, icon, and tab names look like this.**
- Screen captures are examples only.
- The workflows presented here represent one possible scenario. Workflows may vary in practice depending on a particular user's circumstances.

2

Accessing ProviderConnect

Log in to ProviderConnect

To log in to ProviderConnect:

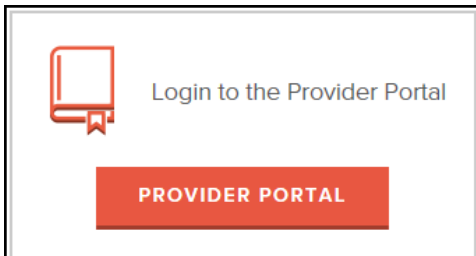
1. Access the following URL: www.beaconhealthoptions.com

The Beacon Health Options home page displays.

2. Click the [Beacon Health Options Providers](#) link on the **Providers** tab.

The Provider Dashboard displays.

3. Click on the [Provider Portal](#) link.



The following screen displays.

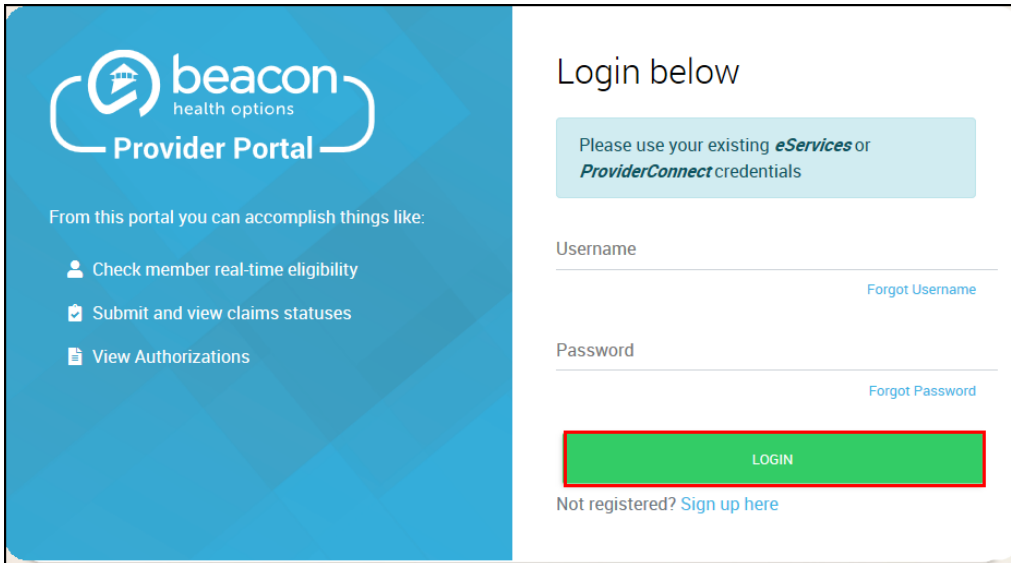


Figure 1: Provider Portal Login Screen

4. Enter your username and password.
5. Click **Login**.
6. Carefully read the Use Agreement and click **Continue**.
7. Select from the list of available plans if applicable and click **Go**.
8. Carefully read the ProviderConnect Use Agreement and select **I Agree**.



ProviderConnect allows submitters belonging to providers with the same NPI# to use a single login to access multiple accounts.



Refer to the [Warn and Restrict Access to ProviderConnect When Attestation Is Due](#) chapter for important information.

Forgot Username

Click on the [Forgot Username](#) link if you have forgotten your user name. The following screen displays.

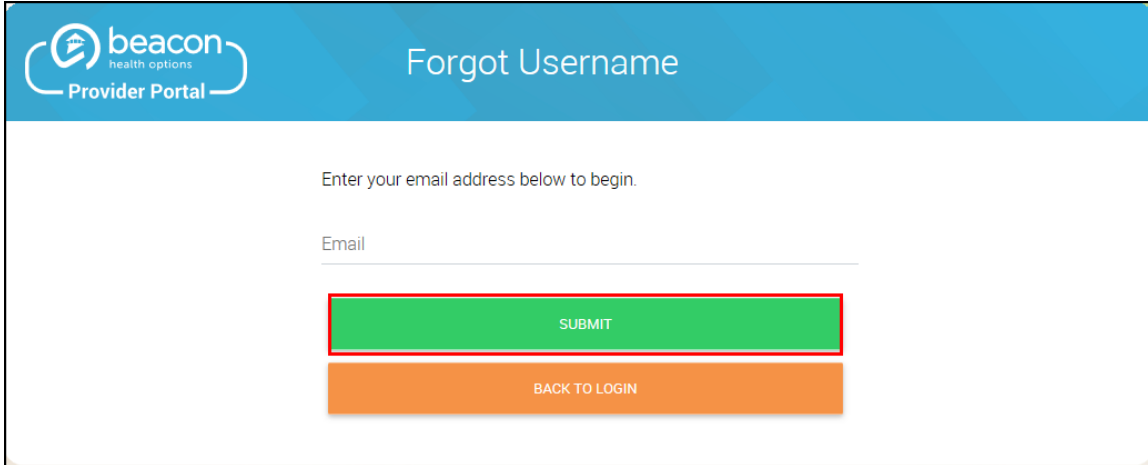


Figure 2: Forgot Username?

Enter your e-mail address and click **Submit**. You will receive an e-mail message containing your user name at the e-mail address on record.

Forgot Password

Click on the [Forgot Password](#) link if you have forgotten your password. The following screen displays.

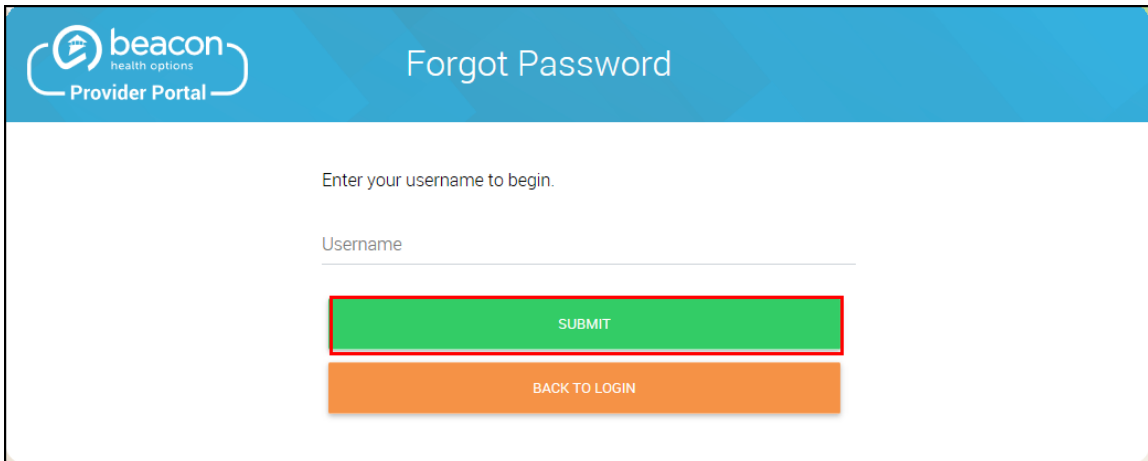


Figure 3: Forgot Password?

Enter your username and click **Submit**. You will receive an e-mail message containing password reset instructions at the e-mail address on record.

New User Registration

New users must register in order to access ProviderConnect. To register, click on [Sign up here](#).

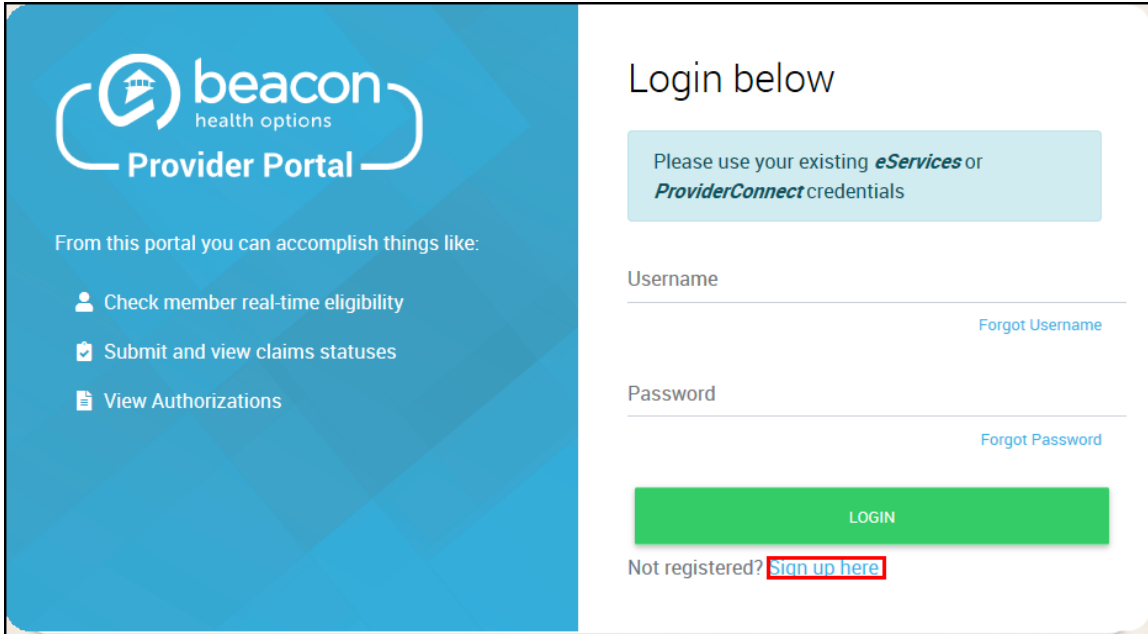


Figure 4: New User Registration

Complete the following information on the Registration page.

Note

An asterisk (*) indicates a required field.

1. Enter the provider's first and last names in the **First Name** and **Last Name** fields.
2. Enter a contact name in the **Contact Name** field.
3. Enter the provider number in the **NPI Number** field.
4. Enter the provider's nine-digit Federal ID or Social Security Number in the **Tax ID** field.
5. Enter the provider's group, facility, or clinic name if applicable.
6. Enter the provider's primary e-mail address in the **Primary Email Address** field.

Note: E-mail addresses must be formatted as [name@company.com](#).

7. Enter the same e-mail address in the **Verify Primary Email Address** field.
8. Enter the provider's secondary e-mail address in the **Secondary Email Address** field.

Note: E-mail addresses must be formatted as [name@company.com](#).

9. Enter a ten-digit phone number in the **Phone Number** field, omitting dashes.
10. Enter an extension in the **Ext** field.
11. Enter a ten-digit fax number in the **Fax Number** field, omitting dashes.
12. Enter a user name in the **Username** field.

13. Enter a password in the **Password** field. (See: [Password Change Rules](#))

Note: Passwords cannot contain spaces and are case-sensitive.

- Passwords must contain at least:
 - One uppercase letter (A-Z),
 - One lowercase letter (a-z),
 - One number (0-9), and
 - One of the following special characters:

!
#
\$
~
"
%
&
'
(
)
*
+
,
-
.
:
;
<
=
>
?
[
\
]
^
_
`
{
}

- Passwords must be between 8 and 20 characters in length.

14. Enter the same password in the **Confirm Password** field.

15. Select a security question.

16. Enter the answer to the security question.
17. Confirm the answer to the security question.
18. Click **Next**.
19. Review the registration details and click **Complete Registration**.

The Additional Information page displays.

20. Select the **Would you like to be able to Submit Claims?** checkbox if applicable.
(See: [Account Request Form](#))
21. Select the **Message Center?** checkbox if you want to be able to send and receive messages. (See: [Your Message Center](#))
22. Click **Continue**.

The Use Agreement page displays.

23. Check the box to confirm that you have read and agree to the Use Agreement and click **Continue**.



Password Change Rules

Users are required to change their passwords every 90 days. A Password Expired page is available that allows a user to change an expired password. The **Submit** and **Cancel** buttons on this page allow the user to either create a new password or cancel the password change.

When a user attempts to update an expired password, the system prohibits “recent” password reuse by not allowing the last 10 passwords to be reused. If a user enters a password that is one of the last 10 passwords used (includes password case-sensitivity), an appropriate error message displays.

Account Request Form



Upon clicking **Would you like to be able to Submit Claims?** and clicking **Continue**, the Use Agreement page displays. Upon agreeing, the Account Request Form displays. The following fields display on this form.

A red asterisk () indicates a required field.*

- Provider Name (pre-populated)
- NPI Number (pre-populated)
- Tax ID (pre-populated)
- Provider Group, Facility or Clinic Name (pre-populated if entered)
- Online Provider Services Options
 - Electronic Batch Claims Submission (837 HIPAA format)
 - Military OneSource Case Activity Form
 - Direct Claims Submission

- Provider has retained a 3rd party Billing Agent or Clearinghouse to submit claims on their behalf. (Yes/No)

Claim Operation Center

The user is required to select a Claim Operation Center and one of the following options.

- Yes (Medicaid)
- No (Commercial Only)
- Both (Medicaid and Commercial)

The user also needs to enter the e-mail address where he/she would like to receive batch submission file feedback if applicable and the provider contact name.

Attestation Page

Upon clicking **Next**, the Attestation page displays pre-populated with the information from the Account Request Form. The user must attest to one of the following:

- I am a provider.
- or-**
- I am office staff of a provider, and am authorized to sign on their behalf.

The following options are available.

- Electronically sign the attestation
- Manually sign and fax the attestation

Electronically Sign the Attestation

To electronically sign the attestation, click on [Click here to sign this document electronically](#). The [Welcome to the Claims e-Signature Process](#) page displays.

Manually Sign and Fax the Attestation

To manually sign and fax the attestation, select the **Check here if you intend to fax the Attestation form** checkbox. (After indicating their intention to fax the form, users should print the document *prior to saving*.)



This action enables the **Continue to ProviderConnect** button.

Welcome to the Claims e-Signature Process

Once on the Welcome to the Claims e-Signature Process page, the user should review the steps to apply an electronic signature and then:

1. Enter his or her full name.
2. Click **Submit**.

The US Federal Consumer Disclosure – E-Sign Act page displays.

3. Carefully read the information on this page.
4. Click on [Yes](#) to signify consent to complete and sign the document electronically. The Signer Information page displays.
5. Enter the user's name to apply to the attestation document.

Note: Users should enter their name as they would normally write it when signing a paper document, using upper and lower case letters as appropriate.

6. Click the **Submit** button to display the e-Claims Agreement Terms.

Note: The applicant's name and application date pre-populate.

7. Click in the highlighted [Click Here to Sign](#) area to electronically sign the document. A Thank You page displays stating that the document has been successfully signed and the user role changed to general claims user.
8. Follow the instructions to download a copy of the document and save it to a local or network drive.

9. Click **Continue to ProviderConnect** to continue to the ProviderConnect home page.

Access Information without Logging On

A number of features are available to providers on the ProviderConnect page (<https://www.beaconhealthoptions.com/providers/beacon/providerconnect/>) without them having to log in. Examples include:

- Forms – Administrative, Clinical, and EAP forms specific to Beacon Health Options
- Provider Handbook – Beacon’s policies and procedures
- Important Tools
- Network-Specific Information – Program-specific handbooks, forms, etc., unique to a particular network
- Contact Information
- Compliance – Federal and state-specific program requirements for maintaining HIPAA-compliant claims submission
- EDI (Electronic Data Interchange) Claims Link for Windows®

3

Warn and Restrict Access to ProviderConnect When Attestation Is Due

As part of the user login, the system checks to see whether ProviderConnect is permitted to make a call to a special NetworkConnect service that identifies providers who are due for demographic attestation. If the system determines that ProviderConnect should call the service, the call is initiated by passing information like the submitter ID and provider ID. (This occurs during provider login and when switching accounts.)

ProviderConnect reads the response from the service to determine whether to display a warning message to the provider.

- If the response indicates the provider is not yet due for attestation, the provider is not warned nor restricted.
- If the response indicates the provider should be warned, ProviderConnect displays a warning message on the Use Agreement page.
- If the response indicates the provider's account should be locked, ProviderConnect displays a warning message on the Use Agreement page and restricts the provider to all but the Update Demographic Information feature.

If the service fails to respond, ProviderConnect logs the provider in without checking his/her attestation status.



Display Warning Message

The following message displays on the Use Agreement page following the Message from Webpage and Message Center pop-ups if the response from the service indicates the provider needs to be warned: "Please review your demographic information and provide attestation in the Provider Demographics page. Your demographic information attestation is due by MM-DD-YYYY for Provider ID XXXXXX. Please verify your information by this date to continue using ProviderConnect. You will have restricted access to ProviderConnect, if you do not attest by this date."

- *MM-DD-YYYY is replaced with the actual due date.*
- *Provider ID XXXXXX is replaced with the actual provider ID.*



Update Provider Demographics / Continue with ProviderConnect

The following buttons display on the warning message pop-up.

- **Update Provider Demographics** – Redirects the user to the Provider Demographics page.
- **Continue with ProviderConnect** – Redirects the user to the ProviderConnect home page.

Restrict User Access

The above warning message also displays for those providers whose accounts should be locked according to the response received from the service. In addition, the following message displays on the ProviderConnect home page: “**Your access is restricted because Provider ID XXXXXX is due for attestation and you will not be able to use all functionalities available in ProviderConnect. Please click on “Update Demographic Information” link to review and provide attestation. Access to ProviderConnect will be restored once you provide your attestation.**”



Provider ID XXXXXX is replaced with the actual provider ID.

4 ProviderConnect Navigation

Users have the ability to navigate ProviderConnect via the main menu or the navigation bar.

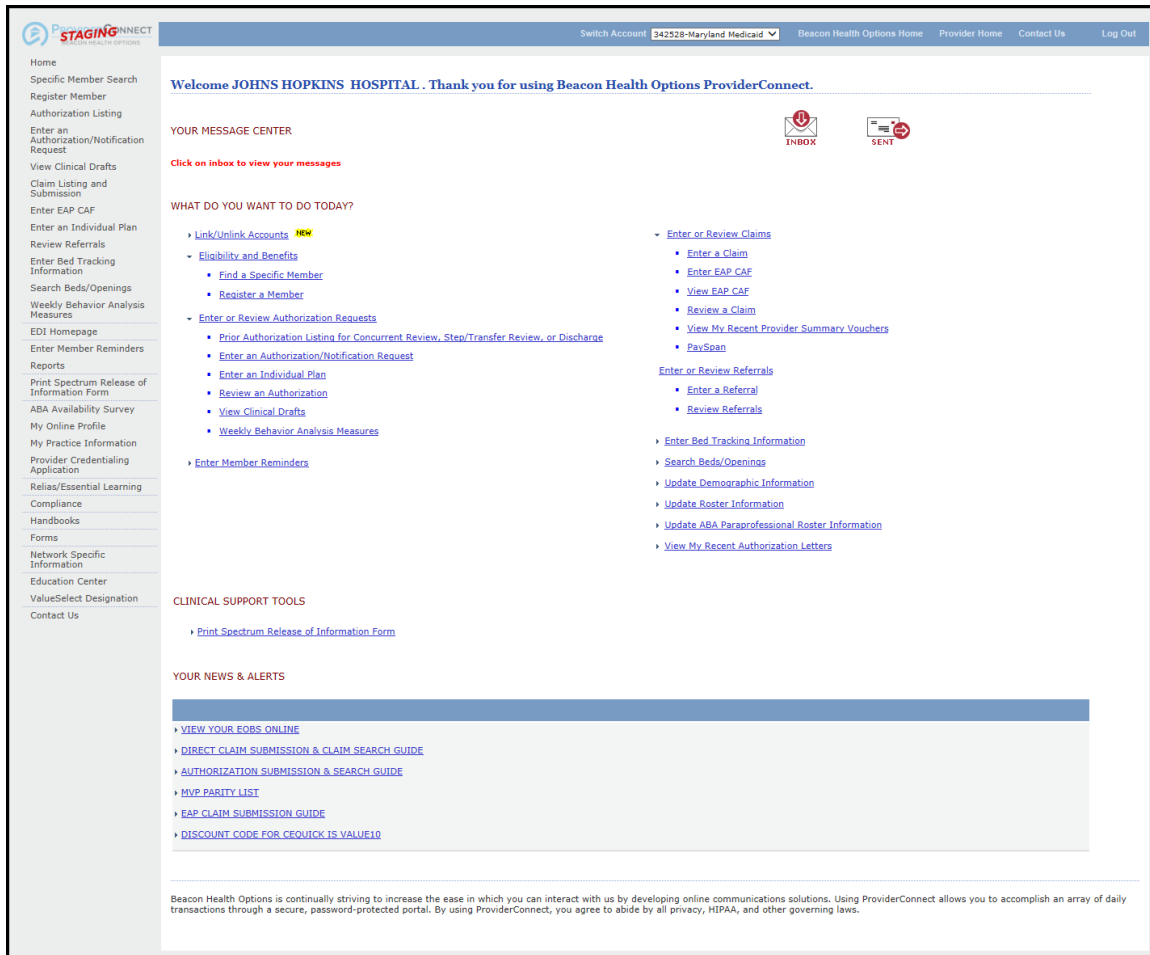


Figure 5: ProviderConnect Home Page Example

Main Menu

A user can access a specific section by clicking the appropriate link on the ProviderConnect main menu. The main menu contains the following options.

- Link/Unlink Accounts – Works in conjunction with the **Switch Account** field. The **Switch Account** field displays all the submitters linked to the logged in ID. (This field defaults to the logged in account regardless of whether or not the submitter has any linked accounts.) The [Link/Unlink Accounts](#) feature allows the user to link or unlink accounts as needed.
- Eligibility and Benefits
 - Find a Specific Member
 - Register a Member
- Enter or Review Claims
 - Enter EAP CAF
 - Enter a Claim
 - Review a Claim
 - View My Recent Provider Summary Vouchers
 - PaySpan – Allows providers to directly access the PaySpan website to retrieve Explanation of Benefits (EOBs) and receive any payments that were submitted electronically.

Note: *The provider must have the appropriate role.*

- Enter or Review Authorization Requests
 - Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge
 - Enter an Authorization/Notification Request
 - Enter an Individual Plan
 - Review an Authorization
 - View Clinical Drafts
 - Weekly ABA Measures
- Enter or Review Referrals
 - Enter a Referral
 - Review Referrals
- Enter Member Reminders
- Enter Case Management Referral
- Enter Bed Tracking Information
- Search Beds/Openings
- Update Demographic Information
- Update Roster Information
- Update ABA Paraprofessional Roster Information
- View My Recent Authorization Letters
- Print Spectrum Release of Information Form

Navigation Bar

A user can access a specific section by clicking the appropriate link on the navigation bar. The options are alphabetized here for ease of use.

- Authorization Listing
- ABA Availability Survey

Note: Provider must have the appropriate user security role along with an active contract that has been set up to use this survey. If not, an error message displays.

- Claim Listing and Submission
- Complete Provider Forms
- Compliance
- Contact Us
- EDI Homepage
- Education Center
- Enter a Comprehensive Service Plan
- Enter a Referral
- Enter a Special Program Application
- Enter a Treatment Plan
- Enter an Authorization/Notification Request
- Enter an Individual Plan
- Enter Bed Tracking Information
- Enter Case Management Referral
- Enter EAP CAF
- Enter Member Reminders
- Forms
- Handbooks
- Home
- Manage Users (Restricted to users with “super user” status)
- My Online Profile
- My Practice Information
- Network Specific Information
- On Track Outcomes
- Performance Report
- Print Spectrum Release of Information Form
- Provider Data Sheet (Facility Data Sheet)
- Provider Data Verification (Available only for DMH providers)
- Register Member
- Reports
- Request for Care
- Review Referrals
- Search Beds/Opening
- Special Application

- Specific Member Search
- ValueSelect Designation
- View Clinical Drafts
- View EOBs
- Weekly ABA Measures

Clinical Support Tools

- View My Outcomes with On Track

News & Alerts

A *News & Alerts* section is also located on the home page. This section displays information disseminated by Beacon Health Options. Providers can view this information by clicking on the links.

Your Message Center

A *Your Message Center* is available that provides a secure message center to ensure confidentiality and to comply with HIPAA requirements. Providers can send messages to and receive messages from Beacon. Providers can also send messages to and receive messages from members. (Refer to the [Secure Provider/Member Communications](#) chapter for more information.)

To view the Inbox, click the **Inbox** icon. The Message Center – Inbox page displays.

- If there are no messages in the provider's Inbox, the following message displays: *"Your Inbox is empty."*
- If there are messages in the provider's Inbox, the following message displays: *"Click on Inbox to view your messages."*



All messages in the provider's Inbox, including messages from Beacon, are available for viewing until the provider deletes them.



To view Sent items, click the **Sent** icon. The Message Center – Sent page displays.

All messages in the provider's Sent Messages, including inquiries and replies sent to Beacon, are available for viewing until the provider deletes them.

5

Secure Provider/Member Communications

ProviderConnect offers providers a secure method of electronic communication between themselves and the member. This chapter focuses on that functionality.

Enable/Disable Communication with All Members

Providers have the ability to either enable or disable communication with all members. A **Use ProviderConnect Message Center to communicate with members? (Yes/No)** field is available in the online profile for that purpose. (Refer to the [My Online Profile](#) chapter for more information.)

- **Yes** – Enables Message Center communication functionality between the provider and all members that the provider has not expressly excluded.
- **No** – Disables Message Center communication functionality between the provider and all members.

Enable/Disable Communication with Individual Members

Providers have the ability to either enable or disable communication with individual members.

- **Enable Communication** – Communication with an individual member is automatically enabled when the provider opts in to the communication functionality *if* the member in question has also opted in to the communication functionality and has not disabled communication with that provider.
- **Disable Communication** –
 - If the provider has opted in to the communication functionality and communication with a member is enabled, the Message Details page displays a **Disable Communication** button that allows the provider to disable communication with that one member. (To disable communication with all members the provider would need to update his/her online profile.)

*If the provider has disabled communication with a member after receiving a message from that member, the Message Details page displays an **Enable Communication** button if the provider has opted in to the communication functionality.*



If the provider has opted in to the communication functionality and communication with a member is enabled, the Member Demographics page displays a **Disable Member Communication** button. This button functions in the same manner as the **Disable Communication** button.

*If the provider has disabled communication with a member, the Member Demographics page displays an **Enable Member Communication** button.*



Send Messages to Members

Providers have the ability to send messages to members via the Member Demographics page. A provider may initiate communication with a member upon executing a successful search for that member. (The member in question must have opted in to the communication functionality.)

A read-only **Member Participates in Message Center Communication with Providers? (Yes/No)** field displays on the Member Demographics page.

- Displays as **Yes** if –
 - The member is an active MemberConnect user, and
 - The member has opted in to the communication functionality, and
 - The member has not disabled communication with that provider.
- Displays as **No** if –
 - The member is not an active MemberConnect user, or
 - The member has opted out of the communication functionality, or
 - The member has disabled communication with that provider.

A **Send Message to Member** button also displays on this page if all the following conditions have been met.

- The provider has the appropriate role assignment, and
- The provider has opted in to the communication function, and
- The provider has not disabled communication with that member, and
- The member has not disabled communication with that provider.

Upon clicking [Send Message to Member](#), the system displays the Send Message to Member page.

Receive Messages from Members

Providers have the ability to receive messages from members. A provider can receive messages from a member if both the following conditions have been met.

- The provider has opted in to the communication functionality, and
- The provider has not disabled communication with that member.

Reply to Messages from Members

Providers have the ability to reply to messages received from members. The Message Details page for member messages contains a message reply section that is similar to the message reply section for Beacon Health Options messages.

View Messages Exchanged with Members

Providers have the ability to view messages sent to members. The system automatically displays all messages and message replies sent to a member in the provider's Message Center Sent Messages. Upon selecting a specific message, a Sent Message Details page displays.

Providers can also view messages received from members. The system automatically displays all messages received from a member in the provider's Message Center Inbox. Upon selecting a specific message, a Message Details page displays.

Print Messages Exchanged with Members

Providers have the ability to print messages and message replies sent to members. The Sent Message Details page contains a **Print** button for that purpose.

Providers can also print messages received from members. The Message Details page contains a **Print** button for that purpose.

Receive New Messages Notifications

Providers have the ability to be automatically alerted when new messages arrive in their Message Center Inbox. The system automatically sends an e-mail notification to the provider whenever a new system-generated or member message arrives in his/her Inbox if the provider has enabled the e-mail notification functionality.

Send New Messages Notifications

The system automatically sends an e-mail notification to the member whenever a new system-generated or provider message is sent to his/her Inbox if the member has answered **Yes** to the **Receive Email Notification Of New Message Center Messages?** question in the MemberConnect online profile.

6 EDI Homepage

The EDI Homepage allows users to access the EDI Transactions page. A user can submit batch files; search files; view previous claims; and view, download, and delete files from within this section.

Beacon can also accommodate batch claims processed via a clearinghouse. If you currently use a clearinghouse, please provide them with Beacon's payer ID: FHC & Affiliates.



Submit a Batch File

To submit a batch file, click the [EDI Homepage](#) link on the navigation bar. The EDI Transactions page displays.

EDI Transactions

Batch Submission. To submit files, select the "Submit Batch File" button below.

Search Files. To find and review the status of submitted files, select the "Search Files" button below.

Submit Batch File

Search Files

*Note: In order to activate your Provider account, please complete the [Account Request Form](#) and return it to ValueOptions.
**Signature must be on file.

Previous Claims File Batch Submissions

Submission #	Result	Date Received	Form #
0119126370	Failed Validation	Mon Sep 12 09:53:57 EDT 2011	837i
0119126369	Failed Validation	Mon Sep 12 09:53:54 EDT 2011	837i
0119126368	Failed Validation	Mon Sep 12 09:53:52 EDT 2011	837i
0119126367	Failed Validation	Mon Sep 12 09:53:46 EDT 2011	837i
0119126366	Failed Validation	Mon Sep 12 09:53:44 EDT 2011	837i
0119126365	Failed Validation	Mon Sep 12 09:53:33 EDT 2011	837i

Figure 6: EDI Transactions

Click the [Submit Batch File](#) link on the navigation bar or click the **Submit Batch File** button on the EDI Transactions page.

The Submit Batch File –Step 1 of 4 page displays.

Complete Four Pages

The following four pages must be completed in order to submit a batch file.

On the Submit Batch File –Step 1 of 4 page, select the required form from the **Form Type** drop-down and click **Next**.

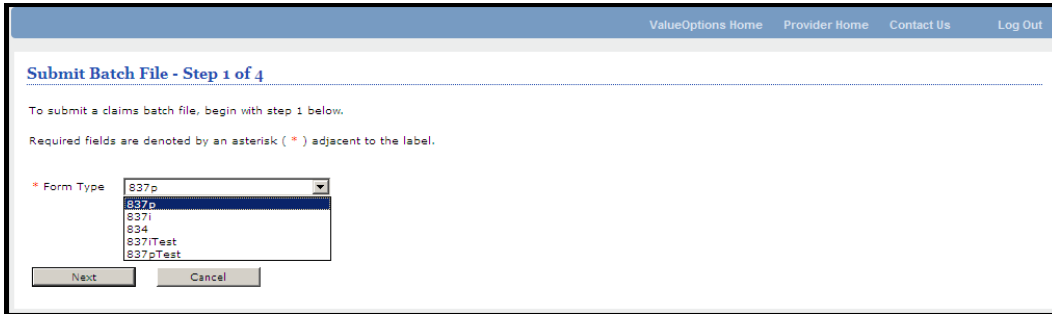


Figure 7: Step 1 of 4

On the Submit Batch File – Step 2 of 4 page:

1. Enter the number of claims in the file in the **How many claims are in this file** field.
2. Enter the total dollar amount of all the claims submitted in the **What is the total dollar amount** field and click **Next**.

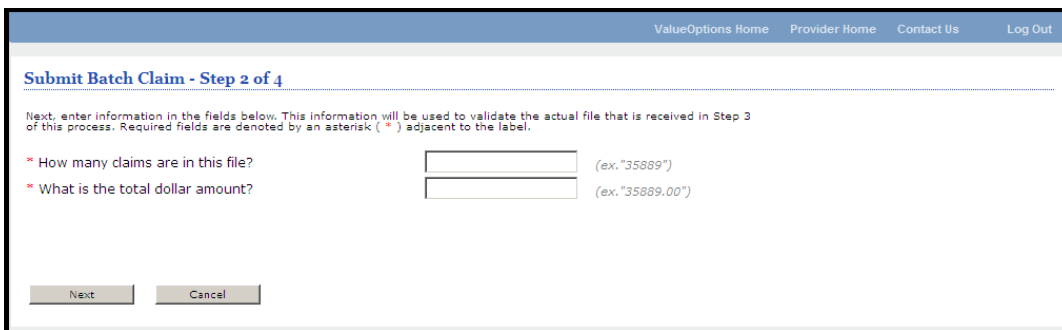


Figure 8: Step 2 of 4

On the Submit Batch File – Step 3 of 4 page:

1. Click **Browse**.

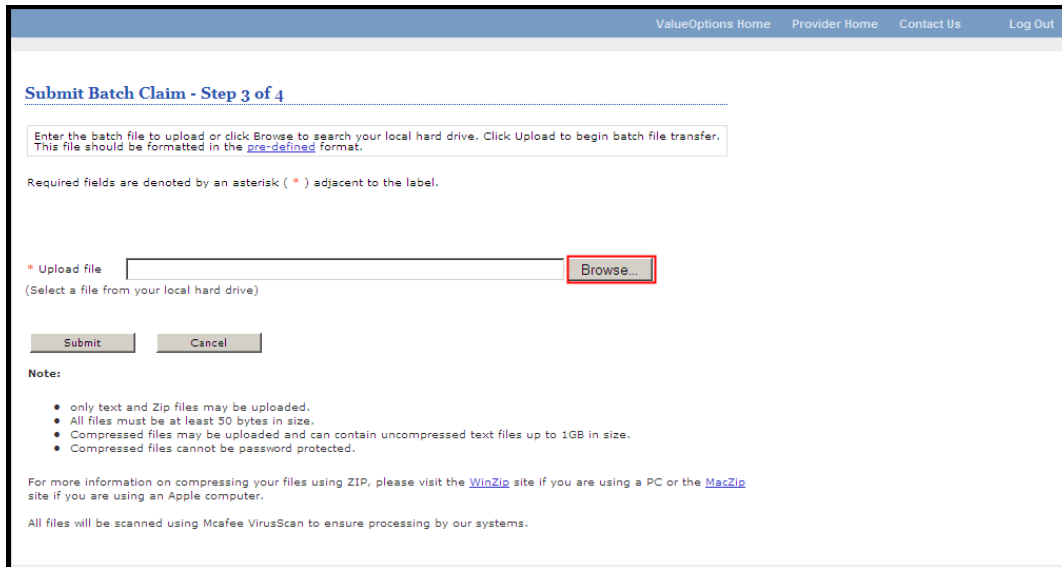


Figure 9: Step 3 of 4

2. Search for the batch file.
3. Select the batch file.
4. Click **Open**.
5. Click **Upload**. The batch file transfer begins.



Some restrictions apply to the files, such as they must be only text or zip files, must be at least 50 bytes in size, and cannot be password-protected.

The Submit Batch File – Step 4 of 4 page displays when the upload is completed. The following information displays on this page.

- A confirmation that the file was successfully uploaded.
- A statement that the submission number will be sent to the registered e-mail address.

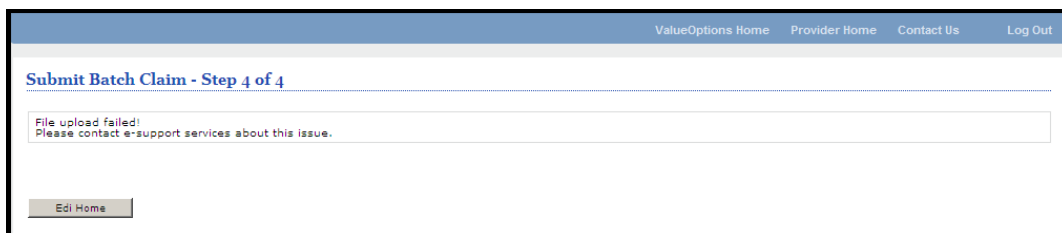


Figure 10: Step 4 of 4

Search Files

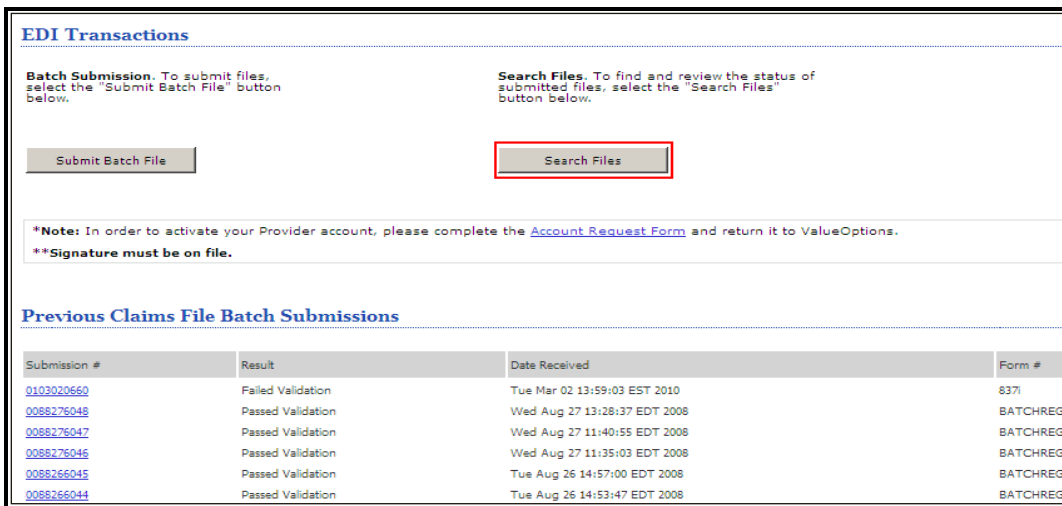
The Search File option on the EDI Transactions page allows users to find and review the status of submitted files.

To search for a file:

1. Click the [EDI Homepage](#) link on the navigation bar.

The EDI Transactions page displays.

2. Click the [Search Files](#) link on the navigation bar or click the **Search Files** button on the EDI Transactions page.



EDI Transactions

Batch Submission. To submit files, select the "Submit Batch File" button below.

Search Files. To find and review the status of submitted files, select the "Search Files" button below.

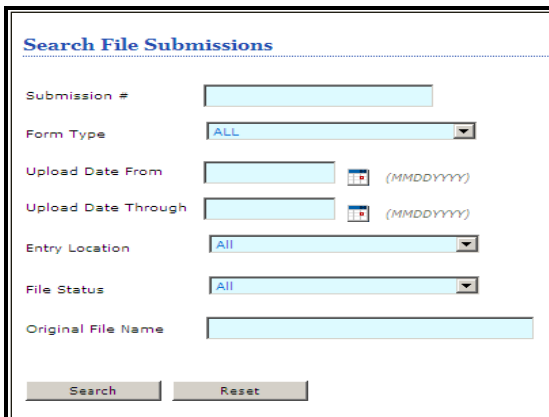
***Note:** In order to activate your Provider account, please complete the [Account Request Form](#) and return it to ValueOptions.
****Signature must be on file.**

Previous Claims File Batch Submissions

Submission #	Result	Date Received	Form #
0103020660	Failed Validation	Tue Mar 02 13:59:03 EST 2010	837I
0088276048	Passed Validation	Wed Aug 27 13:28:37 EDT 2008	BATCHREG
0088276047	Passed Validation	Wed Aug 27 11:40:55 EDT 2008	BATCHREG
0088276046	Passed Validation	Wed Aug 27 11:35:03 EDT 2008	BATCHREG
0088266045	Passed Validation	Tue Aug 26 14:57:00 EDT 2008	BATCHREG
0088266044	Passed Validation	Tue Aug 26 14:53:47 EDT 2008	BATCHREG

Figure 11: Search Files on EDI Transactions

3. Enter information in the fields on the Search File Submissions page.
4. Click **Search**.



Search File Submissions

Submission #

Form Type

Upload Date From (MMDDYYYY)

Upload Date Through (MMDDYYYY)

Entry Location

File Status

Original File Name

Figure 12: Search File Submissions

The Batch Claim Submissions Search Results page displays.

5. Click on the [Tracking #](#) for the file.

Batch Claim Submission Search Results							
49 Submissions found; 49 Submissions displayed.							
Tracking #	Original Filename	Form #	File Status	Upload Date/Time	Processed Date/Time	Total Claims	Claim Amount (\$)
0088215966	88191308.txt	837p	Failed Validation	08/21/2008 10:50:21 AM	08/21/2008 10:50:27 AM	1	101.00
0088215967	88210912.txt	837p	Failed Validation	08/21/2008 11:34:46 AM	08/21/2008 11:34:47 AM	1	101.00
0088215968	88210912.txt	837p	Failed Validation	08/21/2008 11:42:13 AM	08/21/2008 11:42:14 AM	1	101.00
0088215969	88210946.txt	837p	Failed Validation	08/21/2008 11:45:16 AM	08/21/2008 11:45:17 AM	1	101.00
0088215970	88210950.txt	837p	Failed Validation	08/21/2008 11:52:42 AM	08/21/2008 11:52:42 AM	1	101.00
0088215971	88210950.txt	837p	Failed Validation	08/21/2008 11:57:21 AM	08/21/2008 11:57:22 AM	1	101.00
0088215972	88211002.txt	837p	Failed Validation	08/21/2008 12:02:17 PM	08/21/2008 12:02:18 PM	1	101.00

Figure 13: Tracking Number Link

The Submission Detail page displays. This page contains the following information.

- Submission Number
- Form Type
- Upload and Process Date and Time
- Entry Location
- File Status
- Information on the Original File

Submission Detail		
Submission Information - Current as of 03/08/2010 (08:10:15 AM) EST		
Submission Number	0088215966	
Form Type	837p	
Upload Date & Time	08/21/2008 10:50:21 AM EST	
Process Date & Time	08/21/2008 10:50:27 AM EST	
Entry Location	eProvider Website	
File Status	Failed	
ORIGINAL FILE		
File Name	88191308.txt	This file is over 90 days old and has been archived. Please contact e-Support Services with questions or concerns.
File Size	1199 Byte(s)	
Verification Object	ETSHIPAA837pF1	
Export File Name		
Queue Position	0 of 193	
Resubmission Date/Time	Resubmitted By	
0 resubmissions found.		
Error Line #	Description	
1	Invalid data. The Authorization Information field (#2) does not match your ValueOptions EDI Submitter ID setting. Additional Information: No additional information is available. Please contact eSupport Services at 888-247-9311 with any further questions.	
1	Invalid data. The Security Information field (#4) does not match your ValueOptions EDI Password setting. Additional Information: No additional information is available. Please contact eSupport Services at 888-247-9311 with any further questions.	
10	Invalid data. The NPI ID_Code must be 10 numeric characters. 1000007 is invalid. Additional Information: Error occurred in the Billing Provider Information for <2010AA, ANTHONY>.	
14	Provider Secondary Identification is not allowed because the National Provider Identifier has been mandated as the only valid provider identifier for HIPAA transactions. Additional Information: Error occurred in the Billing Provider Information for <2010AA, ANTHONY>.	
15	Provider Secondary Identification is not allowed because the National Provider Identifier has been mandated as the only valid provider identifier for HIPAA transactions. Additional Information: Error occurred in the Billing Provider Information for <2010AA, ANTHONY>.	
25	Invalid data. The NPI ID_Code must be 10 numeric characters. 1000021 is invalid. Additional Information: Error occurred in the Rendering Provider for Patient <2010BA, ANDREA APOLLO>.	
27	Provider Secondary Identification is not allowed because the National Provider Identifier has been mandated as the only valid provider identifier for HIPAA transactions. Additional Information: Error occurred in the Rendering Provider for Patient <2010BA, ANDREA APOLLO>.	
28	Invalid data. The NPI ID_Code must be 10 numeric characters. 1438902 is invalid. Additional Information: Error occurred in the Rendering Provider for Patient <2010BA, ANDREA APOLLO>.	
28	Missing data. The Service_Provider_ID field is required. Additional Information: Error occurred in the Rendering Provider for Patient <2010BA, ANDREA APOLLO>.	
9 errors found.		
Question	Answer	
[submitterid]	[submitterid]	
[test]	[test]	
[password]	[password]	
How many claims are in this file?	1	
What is the total dollar amount?	101.00	
Backend Information	Value	
Backend Code:	PFLO	
Backend Description:	HIPAA 837p Development FLO Files	

Figure 14: Submission Details

View Previous Claims File Batch Submissions

The EDI Transactions page also contains a *Previous Claims File Batch Submissions* section. The six most recent submissions can be viewed in this section. A file search must be conducted to view all the submissions for an account.

EDI Transactions

Batch Submission. To submit files, select the "Submit Batch File" button below.

Search Files. To find and review the status of submitted files, select the "Search Files" button below.

Submit Batch File

Search Files

***Note:** In order to activate your Provider account, please complete the [Account Request Form](#) and return it to ValueOptions.

****Signature must be on file.**

Previous Claims File Batch Submissions

Submission #	Result	Date Received	Form #
0103020660	Failed Validation	Tue Mar 02 13:59:03 EST 2010	837i
0088276048	Passed Validation	Wed Aug 27 13:28:37 EDT 2008	BATCHREG
0088276047	Passed Validation	Wed Aug 27 11:40:55 EDT 2008	BATCHREG
0088276046	Passed Validation	Wed Aug 27 11:35:03 EDT 2008	BATCHREG
0088266045	Passed Validation	Tue Aug 26 14:57:00 EDT 2008	BATCHREG
0088266044	Passed Validation	Tue Aug 26 14:53:47 EDT 2008	BATCHREG

Figure 15: Previous Claims File Batch Submissions

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View Incoming Files

The EDI Transactions page also contains an *Incoming Files* section. All the files that have been sent from Beacon can be viewed in this section.

EDI Transactions

Batch Submission. To submit files, select the "Submit Batch File" button below.

Search Files. To find and review the status of submitted files, select the "Search Files" button below.

Submit Batch File

Search Files

***Note:** In order to activate your Provider account, please complete the [Account Request Form](#) and return it to ValueOptions.

****Signature must be on file.**

Previous Claims File Batch Submissions

Submission #	Result	Date Received	Form #
0103020660	Failed Validation	Tue Mar 02 13:59:03 EST 2010	837I
0088276048	Passed Validation	Wed Aug 27 13:28:37 EDT 2008	BATCHREG
0088276047	Passed Validation	Wed Aug 27 11:40:55 EDT 2008	BATCHREG
0088276046	Passed Validation	Wed Aug 27 11:35:03 EDT 2008	BATCHREG
0088266045	Passed Validation	Tue Aug 26 14:57:00 EDT 2008	BATCHREG
0088266044	Passed Validation	Tue Aug 26 14:53:47 EDT 2008	BATCHREG

Incoming Files

File Name	Date Posted	File Size
#090114EA.txt	Wed Jan 14 19:40:46 EST 2009	8703
#090114EE.txt	Wed Jan 14 19:40:41 EST 2009	950
#090114E R.txt	Wed Jan 14 19:40:35 EST 2009	4235
#090114CA.txt	Wed Jan 14 18:49:00 EST 2009	16439
#090114C R.txt	Wed Jan 14 18:48:55 EST 2009	4235
JN2REG90A.txt	Fri Sep 19 08:21:23 EDT 2008	22241

Figure 16: Incoming Files

1. Click on the [File Name](#).

The View Incoming Files page displays.

2. Click on the [File Name](#) to access the Download File page.

Note: A file can be deleted from this page by clicking on the **Select Files** column and clicking **Delete**.

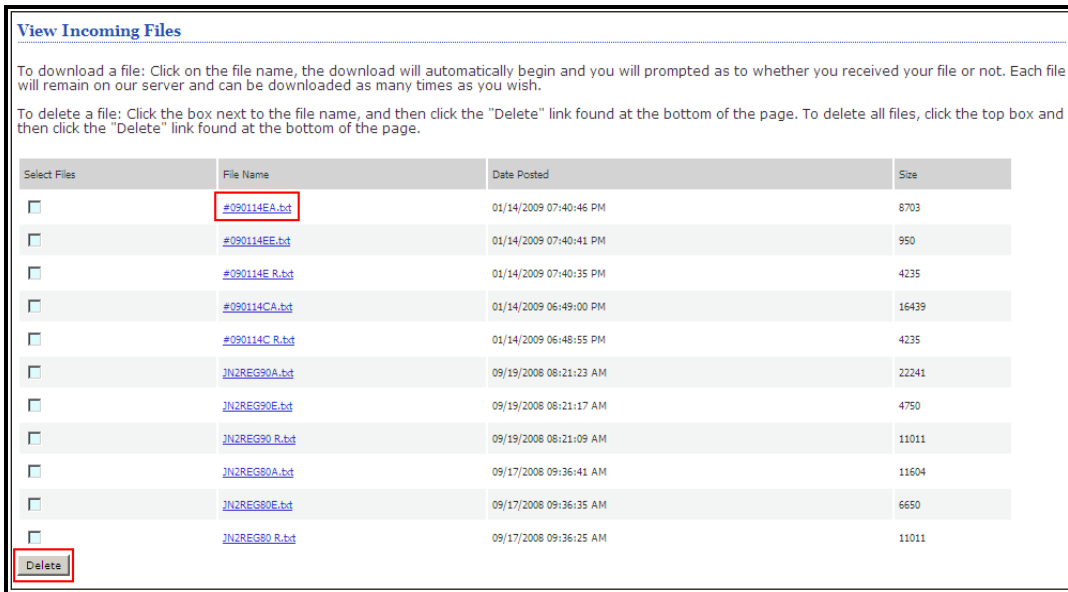


Figure 17: View Incoming Files

The Download File page displays.

3. Click **Yes** if the download was completed successfully.
4. Click **No** if the download was not completed successfully.

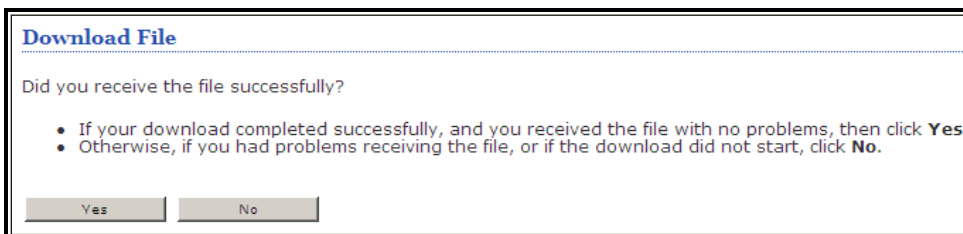


Figure 18: Download a File

If the download was unsuccessful, a page containing instructions displays.

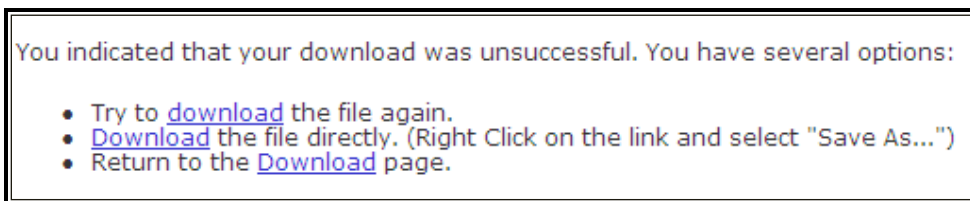


Figure 19: Download Unsuccessful

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Access Member Information

A user can search for and access information for a member via the *Specific Member Search* section of ProviderConnect.

Member Search

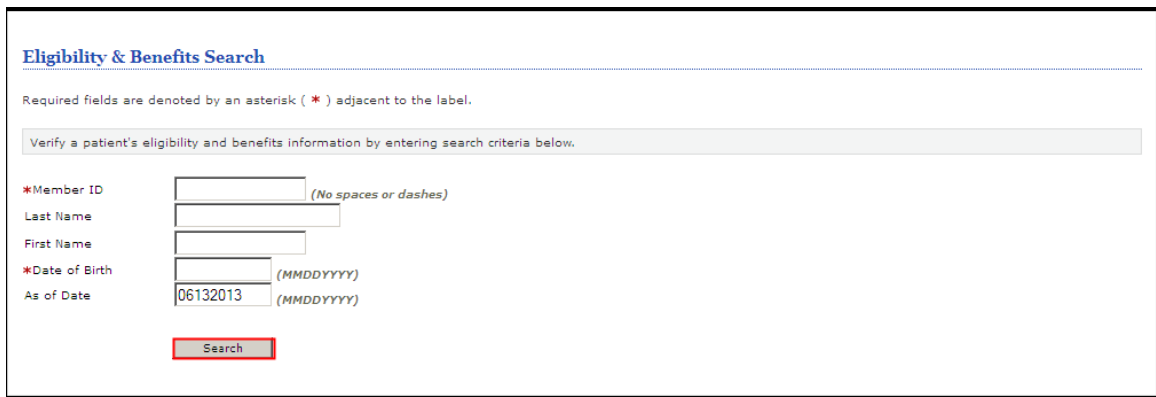
To search for a member, either click [Specific Member Search](#) on the navigation bar or [Find a Specific Member](#) on the ProviderConnect main menu. The Eligibility & Benefits Search page displays.

To retrieve member information:

1. Enter the member ID in the **Member ID** field.
2. Enter a date in the **Date of Birth** field.

Note: Enter information in MMDDYYYY format only.

3. Enter the member's first and last names to narrow the search. (This step is optional.)
4. Click **Search**.



Eligibility & Benefits Search

Required fields are denoted by an asterisk (*) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

*Member ID (No spaces or dashes)

Last Name

First Name

*Date of Birth (MMDDYYYY)

As of Date (MMDDYYYY)

Figure 20: Search Member Eligibility & Benefits



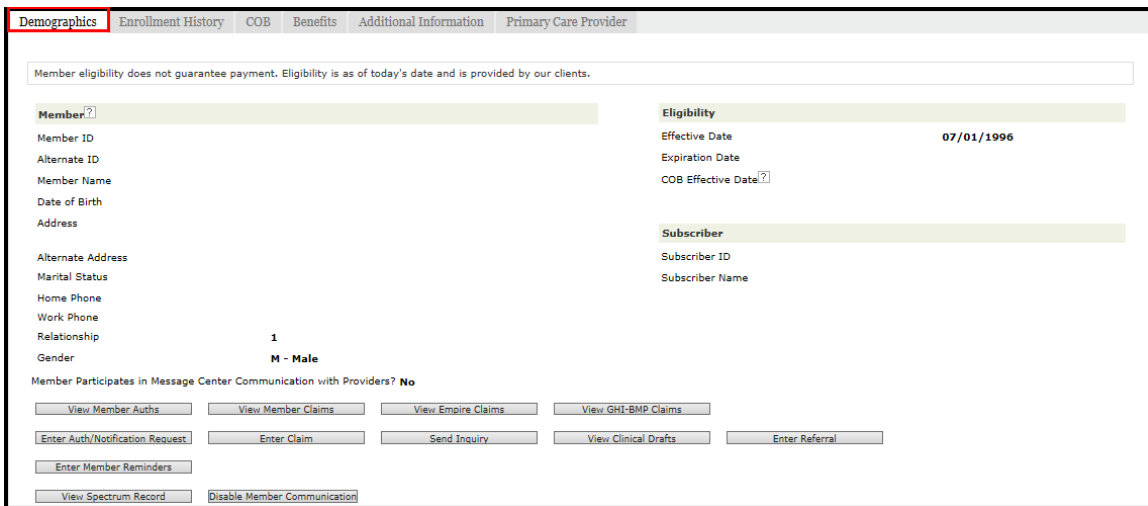
Whenever a provider is using an alternate ID to look up a member, he/she should always start with [Specific Member Search](#) or [Find a Specific Member](#). (Because alternate IDs are shared among family members, this allows the provider to enter a date of birth and locate the correct member.)

Once the search has been completed, the member's information displays in a section that contains the following tabs.

- Demographics – Displays all of the member's demographic information
- Enrollment History – Displays all of the member's enrollments
- COB – Displays information about the member's other insurance policies
- Benefits – Displays the member's benefit information
- Additional Information – Displays the claims mailing address(es), member information, and eligibility data
- Primary Care Provider – Displays detailed information about the member's primary care provider or providers

Demographics Tab

The Demographics tab displays member-specific information such as member ID, name, date of birth, eligibility, and so forth. Claims and authorization/notification requests are displayed for a member ID number that is associated with the provider number entered in the search. If providers have multiple numbers, some of the authorization/notification requests and claims that are linked to different numbers may not display in the search results.



Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Member?	Eligibility
Member ID	Effective Date 07/01/1996
Alternate ID	Expiration Date
Member Name	COB Effective Date?
Date of Birth	
Address	
Alternate Address	
Marital Status	
Home Phone	
Work Phone	
Relationship 1	
Gender M - Male	
Member Participates in Message Center Communication with Providers? No	
View Member Auths	View Member Claims
View Empire Claims	View GHI-BMP Claims
Enter Auth/Notification Request	Enter Claim
Send Inquiry	View Clinical Drafts
Enter Referral	
Enter Member Reminders	
View Spectrum Record	Disable Member Communication

Figure 21: Demographics Tab

Enrollment History Tab

Member enrollment and eligibility information are located on the Enrollment History tab.

The following information can be found in the *Member Detail* section of this page.

- Subscriber ID
- Group #
- Fund
- Expiration Date
- Member ID
- Group Name
- Benefit Package
- Date Changed
- Member Name
- Account #
- Effective Date

On the bottom of the page are tabs used to either retrieve member information or to enter/request member information.

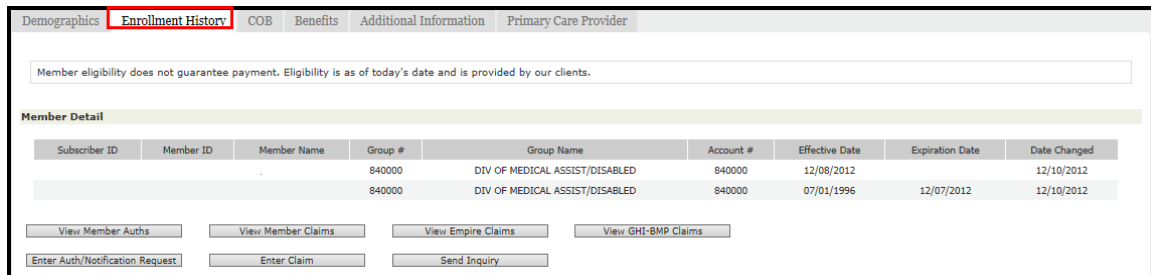
- View Member Auths – Displays all the authorizations for the member
- View Member Claims – Displays information about the member’s claims
- View Empire Claims – Displays Empire Claims

Note: *Applicable only to the Empire Client.*

- View GHI-BMP Claims – Displays GHI-BMP Claims
- Enter Auth/Notification Request – Authorization/notification requests can be submitted electronically
- Enter Claim – Claims can be submitted for a member electronically
- Send Inquiry – Inquiries can be submitted to the Beacon Customer Service Center electronically



The same buttons are located on the next four member tabs as well.

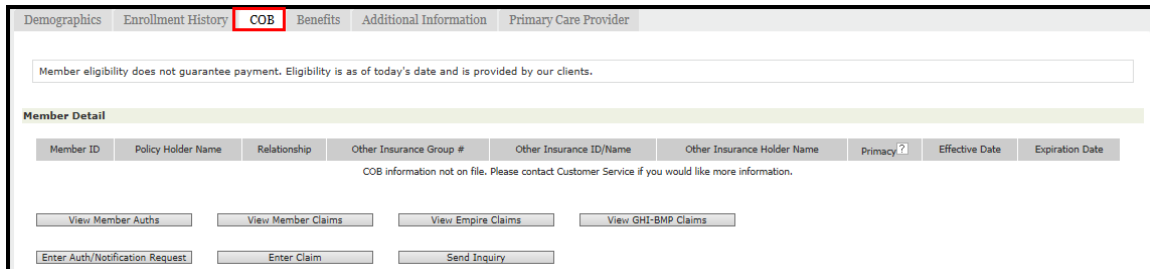


Subscriber ID	Member ID	Member Name	Group #	Group Name	Account #	Effective Date	Expiration Date	Date Changed
			840000	DIV OF MEDICAL ASSIST/DISABLED	840000	12/08/2012		12/10/2012
			840000	DIV OF MEDICAL ASSIST/DISABLED	840000	07/01/1996	12/07/2012	12/10/2012

Figure 22: Enrollment History Tab

COB Tab

If applicable, additional insurance information for a specific member displays on the Coordination of Benefits (COB) tab. Some of the same buttons on the bottom of the Demographics page also display on the bottom of the COB page.



Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Member Detail

Member ID	Policy Holder Name	Relationship	Other Insurance Group #	Other Insurance ID/Name	Other Insurance Holder Name	Primary	Effective Date	Expiration Date
COB information not on file. Please contact Customer Service if you would like more information.								

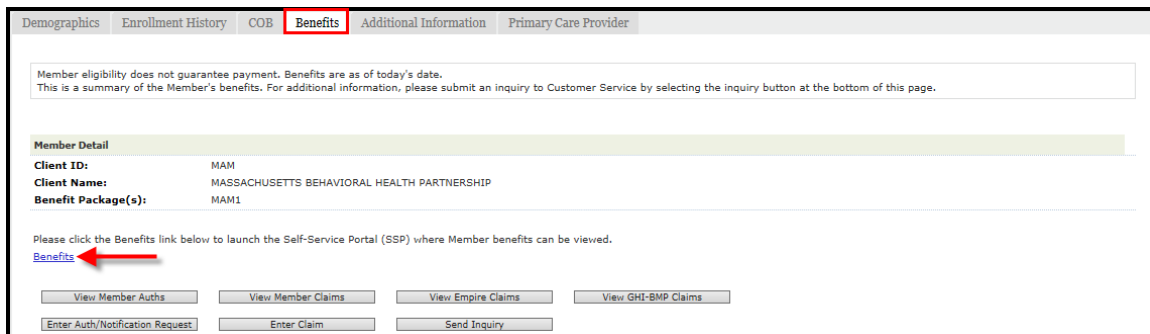
View Member Auths View Member Claims View Empire Claims View GHI-BMP Claims

Enter Auth/Notification Request Enter Claim Send Inquiry

Figure 23: COB Tab

Benefits Tab

Upon clicking the [Benefits](#) link, the user is redirected to the Self-Service Portal (SSP) application where he/she can view detailed benefit information for the member.



Member eligibility does not guarantee payment. Benefits are as of today's date.
This is a summary of the Member's benefits. For additional information, please submit an inquiry to Customer Service by selecting the inquiry button at the bottom of this page.

Member Detail

Client ID: MAM
Client Name: MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP
Benefit Package(s): MAM1

Please click the Benefits link below to launch the Self-Service Portal (SSP) where Member benefits can be viewed.

[Benefits](#)

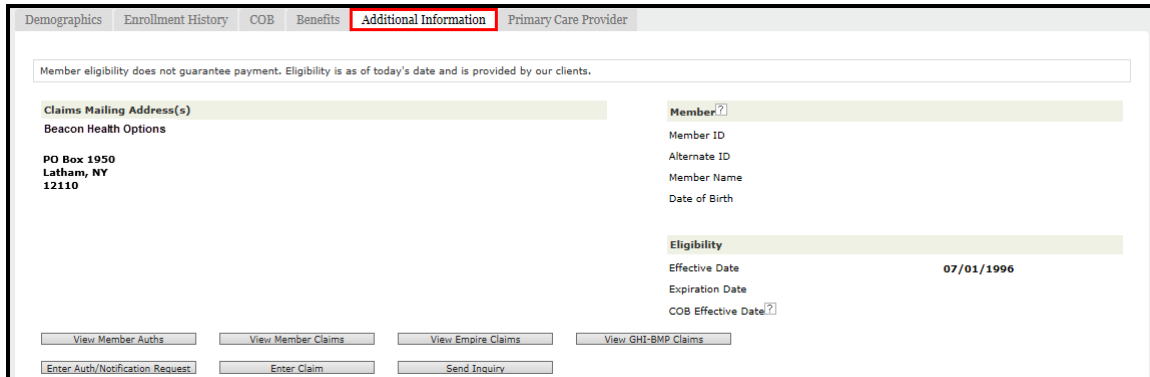
View Member Auths View Member Claims View Empire Claims View GHI-BMP Claims

Enter Auth/Notification Request Enter Claim Send Inquiry

Figure 24: Benefits Tab

Additional Information Tab

The Additional Information tab displays the claims mailing address(es), member information, and eligibility data.



Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Claims Mailing Address(s)	Member?
Beacon Health Options PO Box 1950 Latham, NY 12110	Member? Member ID Alternate ID Member Name Date of Birth

Eligibility	
Effective Date	07/01/1996
Expiration Date	
COB Effective Date?	

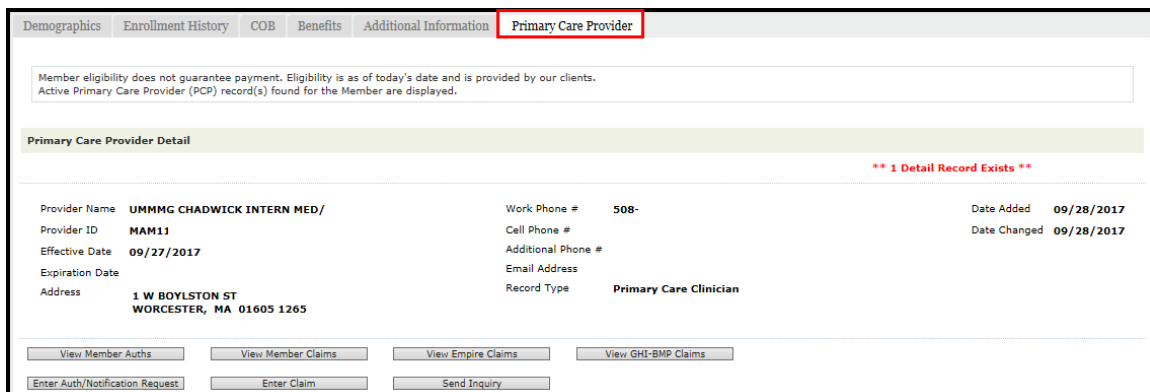
[View Member Auths](#)
[View Member Claims](#)
[View Empire Claims](#)
[View GHI-BMP Claims](#)

[Enter Auth/Notification Request](#)
[Enter Claim](#)
[Send Inquiry](#)

Figure 25: Additional Information Tab

Primary Care Provider Tab

The Primary Care Provider tab displays detailed information about the member's primary care provider or providers.



Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.
Active Primary Care Provider (PCP) record(s) found for the Member are displayed.

Primary Care Provider Detail

**** 1 Detail Record Exists ****

Provider Name	UMMMG CHADWICK INTERN MED/	Work Phone #	508-	Date Added	09/28/2017
Provider ID	MAM11	Cell Phone #		Date Changed	09/28/2017
Effective Date	09/27/2017	Additional Phone #			
Expiration Date		Email Address			
Address	1 W BOYLSTON ST WORCESTER, MA 01605 1265	Record Type	Primary Care Clinician		

[View Member Auths](#)
[View Member Claims](#)
[View Empire Claims](#)
[View GHI-BMP Claims](#)

[Enter Auth/Notification Request](#)
[Enter Claim](#)
[Send Inquiry](#)

Figure 26: Primary Care Provider Tab

8

View Member Authorizations & Claims Information

As previously mentioned, there are a number of buttons on the Member tabs. These buttons are:

- View Member Auths
- View Member Claims
- View Empire Claims

Note: *Applicable only to the Empire Client.*

- View GHI-BMP Claims
- Enter Auth/Notification Request
- Enter Claim
- Send Inquiry
- View Clinical Drafts
- Enter Member Reminders
- View Member Registrations
- View Spectrum Record

View Member Authorizations

To view member authorizations:

1. Click the **View Member Auths** button. The following fields display with some of the information already populated.
 - Provider ID
 - Auth #
 - Service From/Through
2. Click **Search**.

The Authorization Search Results page displays. This page contains information about member-specific authorizations. Clicking the links on this page enables providers to view authorization letters, authorization summary, and authorization details information.

View an Authorization Letter

To view an authorization letter:

1. Click the **View Letter** icon on the Authorization Search Results page.

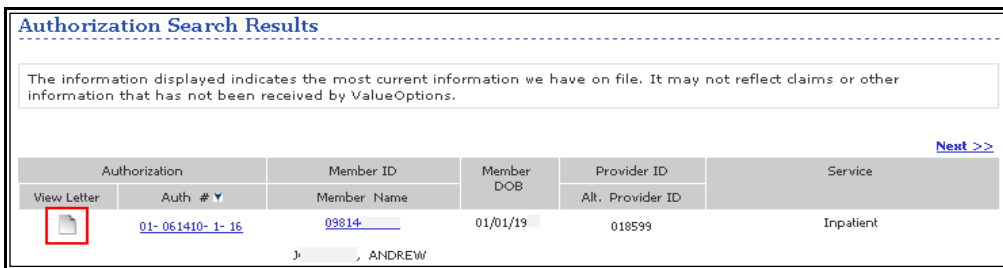


Figure 27: View Letter Icon

2. Click on the [View](#) link to display the authorization letter.

The Authorization Letter displays.

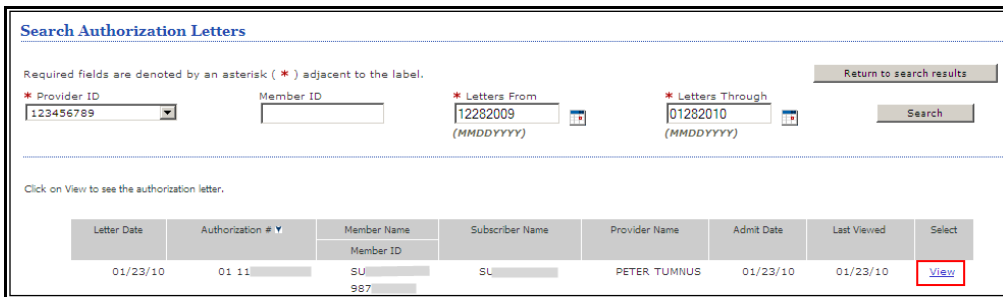


Figure 28: View Letter Link

View Member Claims

A user can search for information about a specific member claim.

1. Click **View Member Claims**.

***Note:** This button also appears on the Enrollment History, COB, Benefits, Additional Information, and Primary Care Provider pages.*

The following fields display with some of the information already populated.

- Provider ID
- Claim #
- Service From/Through

2. Click **Search**.

The Member Claims Results displays.

3. Select a provider ID from the **Provider ID** drop-down if necessary.
4. Enter the claim number in the **Claim ID** field.
5. Enter the service start date in the **Service From** field.
6. Enter the service end date in the **Service Through** field.
7. Click **Search**.

The Claims Search Results page displays all the claims that meet the selected criteria.

- Claim Number
- Member Name and ID Number
- Provider ID Number
- Vendor Name and ID Number
- Dates of Service
- Claim Status
- Charge Amount (\$)

To review the information about a specific claim, click on the [Claim #](#).

View Empire Claims

A user can search for information on an Empire claim for a member by clicking the **View Empire Claims** button.



Applicable only to the Empire Client.

To view information about Empire claims:

1. Click the **View Empire Claims** button on the Enrollment History tab.

Note: This button also appears on the COB, Benefits, Additional Information, and Primary Care Provider pages.

2. Follow the directions for entering claim information in the [View Member Claims](#) section of this user guide.

The Empire Claims Search Results page displays all the claims that meet the selected criteria.

- Claim Number
- Member Name and ID Number
- Provider ID Number
- Vendor Name and ID Number
- Dates of Service
- Claim Status
- Charge Amount (\$)
- Paid Amount (\$)

To review the information about a specific claim, click on the [Claim #](#).

View GHI-BMP Claims

A user can search for information on a GHI-BMP claim for a member by clicking the **View GHI-BMP Claims** button. To view information on GHI-BMP claims:

1. Click the **View GHI-BMP Claims** button on the Demographics tab.

Note: This button also appears on the Enrollment History, COB, Benefits, Additional Information, and Primary Care Provider pages.

2. Follow the directions for entering claim information in the [View Member Claims](#) section of this user guide.

The GHI-BMP Claims Search Results page displays all the claims that meet the selected criteria. The following information displays on this page.

- Claim Number
- Member Name and ID Number
- Provider ID Number
- Vendor Name and ID Number
- Dates of Service

- Charge Amount (\$)
- Paid Amount (\$)

To review the information about a specific claim, click on the [Claim #](#).

Enter Member Reminders

A user can enter member reminder information, allowing appointment and medication reminders to be displayed.

1. Click the **Enter Member Reminders** button on the Demographics tab.



The Enter Member Reminders page displays the member ID and member name, with links pertaining to setting up appointment and medication reminders.

Clicking on the [Member ID](#) redirects you to the Member Demographics page.

2. Click on each link and enter the necessary information for setting up reminders.

View Member Registrations

A user can enter/view member registration information. This allows demographic information to be captured and saved for a specific member.

1. Click the **View Member Registrations** button on the Demographics tab.
2. Enter the member information.

Enter an Authorization Request

Refer to the [Enter an Authorization Request \(RFS\)](#) chapter for detailed information about how to enter authorization requests (requests for services).

Enter a Claim

A user can enter and submit a claim for a member electronically.

1. Click the **Enter Claim** button.

Note: This button also appears on the Enrollment History, COB, Benefits, Additional Information, and Primary Care Provider pages.

The Provider page displays.

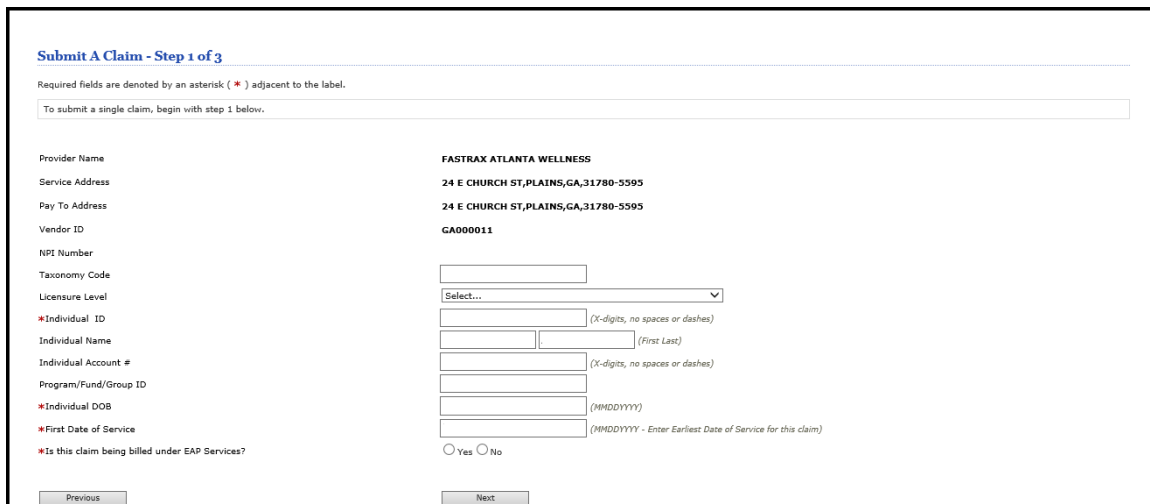
2. Select an option from the **Select Service Address** list and click **Next**.

The Submit A Claim – Step 1 of 3 page displays. (Note that the Member ID and Member DOB fields pre-populate.)

3. Select a different **NPI Number** if necessary. (Defaults to the first number in the list if there are multiple NPI numbers. Otherwise, displays just the one number.)
4. Enter a **Taxonomy Code**.
5. Enter the earliest date of service for the claim in the **First Date of Service** field.
6. Select either **Yes** or **No** in the **Is this claim being billed under EAP Services?** field and click **Next**.



The **Next** button is disabled if the claim cannot be processed.



Submit A Claim - Step 1 of 3

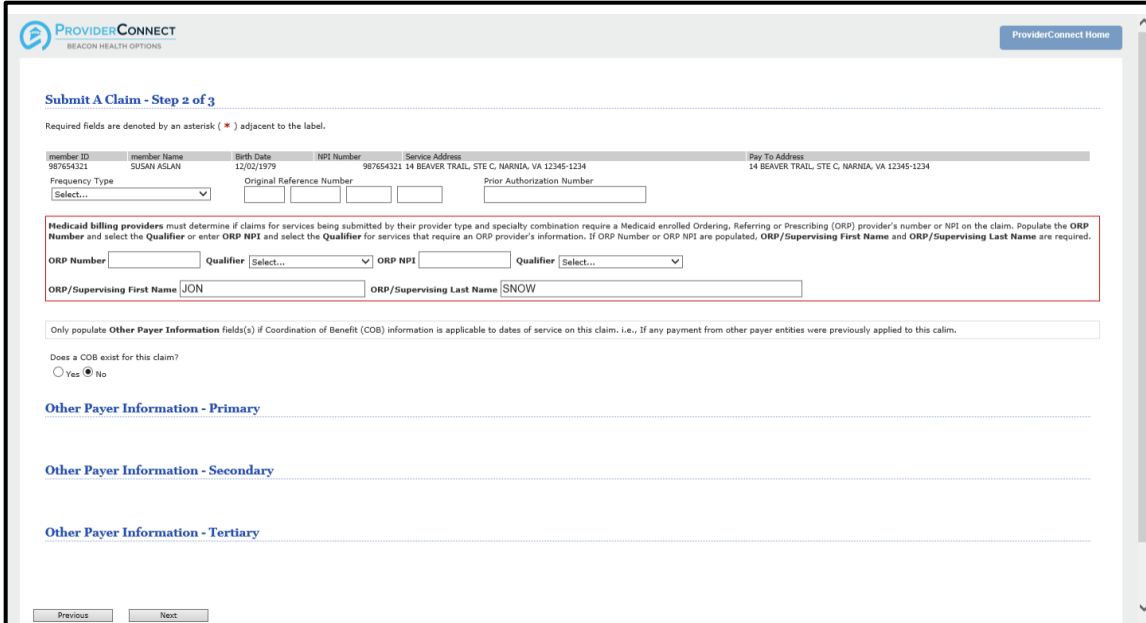
Required fields are denoted by an asterisk (*) adjacent to the label.

To submit a single claim, begin with step 1 below.

Provider Name	FASTRAX ATLANTA WELLNESS
Service Address	24 E CHURCH ST, PLAINS, GA, 31780-5595
Pay To Address	24 E CHURCH ST, PLAINS, GA, 31780-5595
Vendor ID	GA000011
NPI Number	<input type="text"/>
Taxonomy Code	<input type="text"/>
Licensure Level	<input type="text" value="Select..."/>
* Individual ID	<input type="text"/> (X-digits, no spaces or dashes)
Individual Name	<input type="text"/> (First Last)
Individual Account #	<input type="text"/> (X-digits, no spaces or dashes)
Program/Fund/Group ID	<input type="text"/>
* Individual DOB	<input type="text"/> (MMDDYYYY)
* First Date of Service	<input type="text"/> (MMDDYYYY - Enter Earliest Date of Service for this claim)
* Is this claim being billed under EAP Services?	<input type="radio"/> Yes <input type="radio"/> No

Figure 29: Submit a Claim – Step 1 of 3

The Submit A Claim (Step 2 of 3) page displays. Complete any applicable fields and click **Next**.



Submit A Claim - Step 2 of 3

Required fields are denoted by an asterisk (*) adjacent to the label.

Member ID 987654321	Member Name SUSAN ASLAN	Birth Date 12/02/1979	NPI Number 987654321	Service Address 14 BEAVER TRAIL, STE C, NARMDA, VA 12345-1234	Pay To Address 14 BEAVER TRAIL, STE C, NARMDA, VA 12345-1234
------------------------	----------------------------	--------------------------	-------------------------	--	---

Frequency Type
Select...

Original Reference Number
[] [] [] []

Prior Authorization Number
[] [] [] [] [] [] [] [] [] []

Medicaid billing providers must determine if claims for services being submitted by their provider type and specialty combination require a Medicaid enrolled Ordering, Referring or Prescribing (ORP) provider's number or NPI on the claim. Populate the ORP Number and select the Qualifier or enter ORP NPI and select the Qualifier for services that require an ORP provider's information. If ORP Number or ORP NPI are populated, ORP/Supervising First Name and ORP/Supervising Last Name are required.

ORP Number [] Qualifier Select... ORP NPI [] Qualifier Select...

ORP/Supervising First Name JON ORP/Supervising Last Name SNOW

Only populate Other Payer Information field(s) if Coordination of Benefit (COB) information is applicable to dates of service on this claim. i.e., if any payment from other payer entities were previously applied to this claim.

Does a COB exist for this claim?
☐ Yes ☒ No

[Other Payer Information - Primary](#)

[Other Payer Information - Secondary](#)

[Other Payer Information - Tertiary](#)

Previous Next

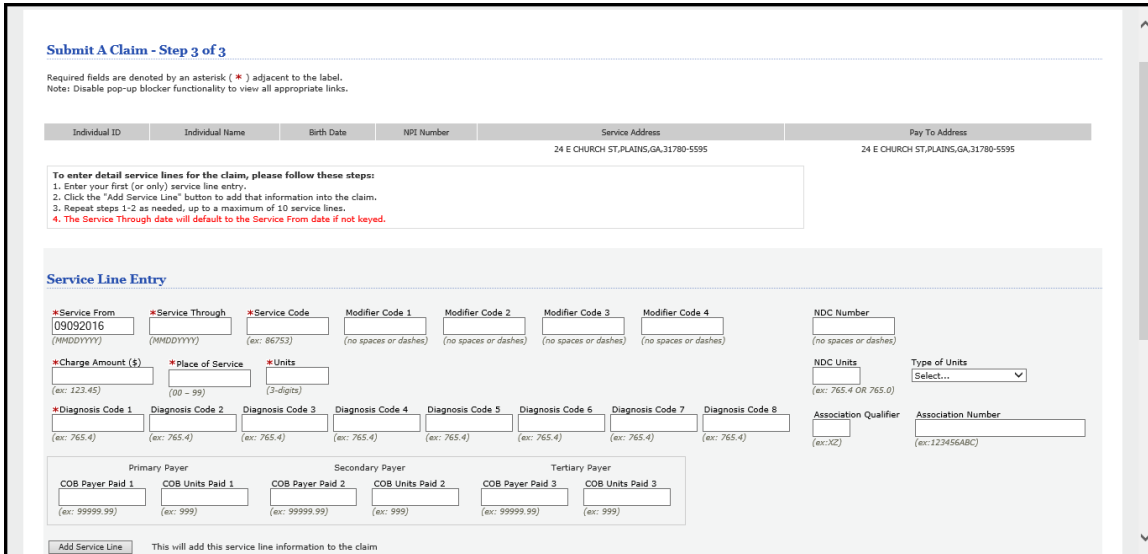
Figure 30: Submit a Claim – Step 2 of 3

The Submit A Claim (Step 3 of 3) page displays. Complete the *Service Line Entry* section.

1. Enter dates in the **Service From** and **Service Through** fields.
2. Enter a code in the **Service Code** field.
3. Enter codes, if needed, in the **Modifier Code 1, 2, 3, and 4** fields.
4. Enter a dollar amount in the **Charge Amount (\$)** field.
5. Enter a code (from 00-99) in the **Place of Service** field.
6. Enter a number (up to three digits) in the **Units** field.
7. Enter a code (e.g., 765.04) in the **Diagnosis Code 1** field.
8. Enter codes, if needed, in the **Diagnosis Code 2, 3, 4, 5, 6, 7, and 8** fields.
9. Enter codes, if needed, in the **Primary Payer, Secondary Payer, and Tertiary Payer** fields.
10. Complete the **National Drug Code (NDC)** fields if applicable. (Note that these fields may not apply to all users!)
 - NDC Number (Allows 48 characters maximum. Must be all numerals.)
 - NDC Units (Allows 19 characters maximum; up to 17 digits, a decimal point, and 1 decimal place. For example: 12345678901234567.0)
 - Type of Units
 - UN – Unit
 - ML – Milliliter
 - ME – Milligram
 - GR – Gram
 - F2 – International Unit

Note: The National Drug Code is a unique product identifier used in the United States for drugs that are intended for human use.

11. Complete the **Association Qualifier** field if applicable. (Note that this field may not apply to all users, but is required if an association number is entered.)
12. Complete the **Association Number** field if applicable. (Note that this field may not apply to all users, but is required if an association qualifier is entered.)
13. Click the **Add Service Line** button. (The Claim Detail: Ready to Submit page displays.)



Submit A Claim - Step 3 of 3

Required fields are denoted by an asterisk (*) adjacent to the label.
Note: Disable pop-up blocker functionality to view all appropriate links.

Individual ID	Individual Name	Birth Date	NPI Number	Service Address	Pay To Address
				24 E CHURCH ST, PLAINS, GA, 31780-5595	24 E CHURCH ST, PLAINS, GA, 31780-5595

To enter detail service lines for the claim, please follow these steps:
1. Enter your first (or only) service line entry.
2. Click the "Add Service Line" button to add that information into the claim.
3. Repeat steps 1-2 as needed, up to a maximum of 10 service lines.
4. The Service Through date will default to the Service From date if not keyed.

Service Line Entry

*Service From (09092016) (MMDDYYYY)	*Service Through (MMDDYYYY)	*Service Code (ex: 86753)	Modifier Code 1 (no spaces or dashes)	Modifier Code 2 (no spaces or dashes)	Modifier Code 3 (no spaces or dashes)	Modifier Code 4 (no spaces or dashes)	NDC Number (no spaces or dashes)
*Charge Amount (\$) (ex: 123.45)	*Place of Service (00 - 99)	*Units (3-digits)	Diagnosis Code 1 (ex: 765.4)	Diagnosis Code 2 (ex: 765.4)	Diagnosis Code 3 (ex: 765.4)	Diagnosis Code 4 (ex: 765.4)	Diagnosis Code 5 (ex: 765.4)
Diagnosis Code 6 (ex: 765.4)	Diagnosis Code 7 (ex: 765.4)	Diagnosis Code 8 (ex: 765.4)	Association Qualifier (ex: X2)	Association Number (ex: 123456ABC)			

Primary Payer: COB Payer Paid 1 (ex: 9999.99), COB Units Paid 1 (ex: 999)

Secondary Payer: COB Payer Paid 2 (ex: 9999.99), COB Units Paid 2 (ex: 999)

Tertiary Payer: COB Payer Paid 3 (ex: 9999.99), COB Units Paid 3 (ex: 999)

Add Service Line This will add this service line information to the claim

Figure 31: Submit a Claim – Step 3 of 3

Click **Submit** to submit the entire claim.

To remove a service line:

1. Select the **Click to Remove** option button.
2. Click **Remove**.
3. Click **Previous** to return to the preceding provider and member entry page.

After the claim has been submitted, the Submit A Claim page displays. This page shows the submission results and the claim information.

Clicking on the [Claim #](#) directs the user to the Claim Summary page.

Send an Inquiry

A user can submit an inquiry about a member to the Beacon Customer Service Center electronically.

1. Click **Send Inquiry**.

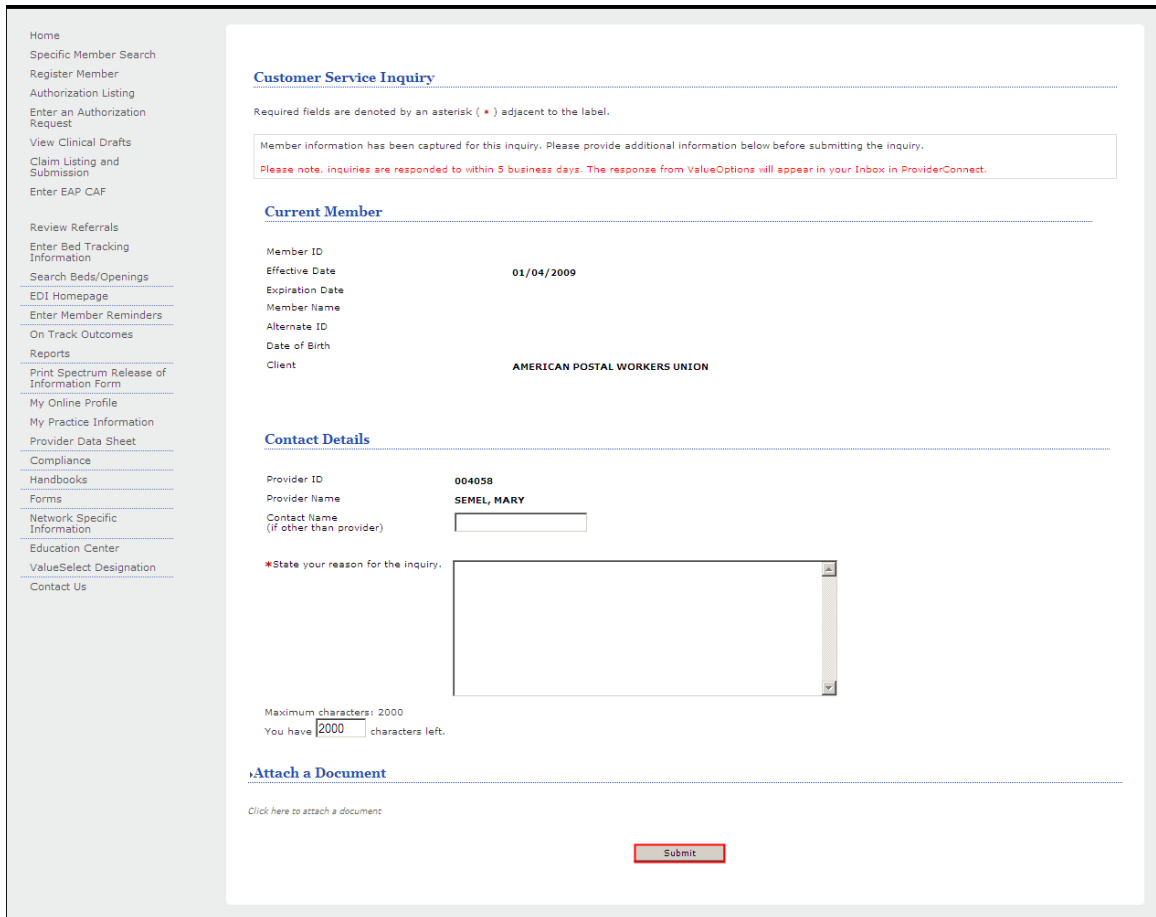
Note: This button also appears on the Enrollment History, COB, Benefits, Additional Information, and Primary Care Provider pages.

The Customer Service Inquiry page displays.

2. Review the information in the Current Member section for accuracy.
3. Enter a name in the **Contact Name** field if necessary.
4. Enter the reason for the inquiry in the **State your reason for the inquiry** text box.

Note: This text box accepts up to 2,000 characters.

5. Attach a document if applicable.
6. Click **Submit**.



Customer Service Inquiry

Required fields are denoted by an asterisk (*) adjacent to the label.

Member information has been captured for this inquiry. Please provide additional information below before submitting the inquiry.

Please note, inquiries are responded to within 5 business days. The response from ValueOptions will appear in your Inbox in ProviderConnect.

Current Member

Member ID	
Effective Date	01/04/2009
Expiration Date	
Member Name	
Alternate ID	
Date of Birth	
Client	AMERICAN POSTAL WORKERS UNION

Contact Details

Provider ID	004058
Provider Name	SEMEI, MARY
Contact Name (if other than provider)	<input type="text"/>

*State your reason for the inquiry.

Maximum characters: 2000
You have characters left.

Attach a Document

Click here to attach a document

Figure 32: Customer Service Inquiry

The inquiry will be sent to the Beacon Customer Service Center, and a confirmation of the submission and an inquiry number will be displayed.

9 Authorization Listing

In this section of ProviderConnect, a user can search for information on provider-specific authorizations (e.g., authorization letters, associated claims).

*To research a specific member's authorizations, select **Specific Member Search** on the navigation bar instead of selecting **Authorization Listing**.*

Note

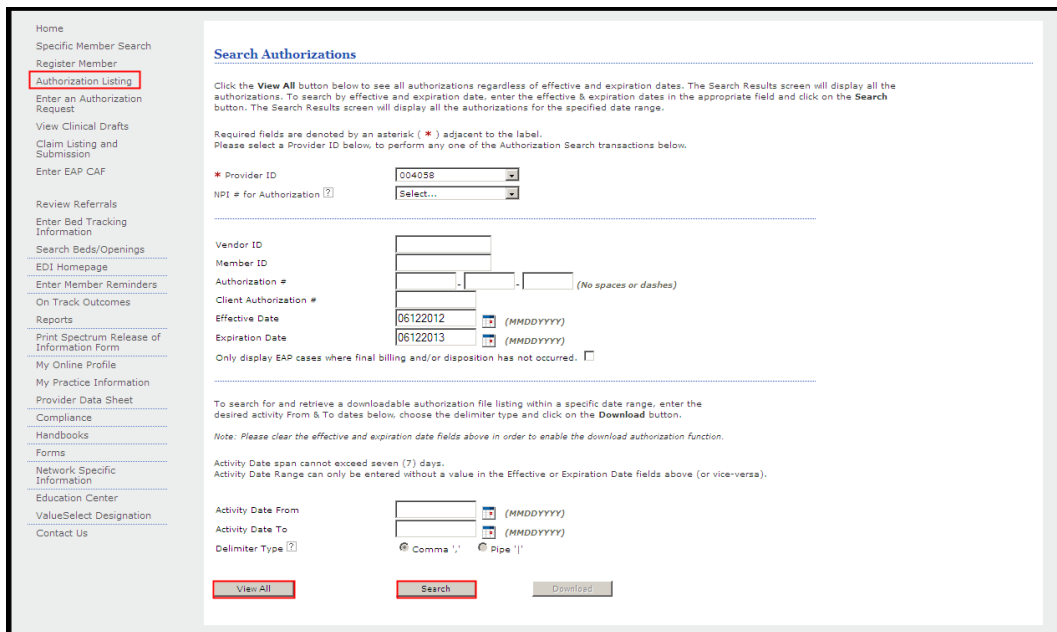
Upon clicking either [Authorization Listing](#) or [Review an Authorization](#), the Search Authorizations page displays. Click **View All** to see all the authorizations for the provider. (The Search Results page displays all the authorizations.)

Results can be sorted by member ID, member name, or authorization number.

Note

-OR-

1. Enter a number in the **Authorization #** field.
2. Enter a date range in the **Effective Date** and **Expiration Date** fields.
3. Click **Search**. (The Search Results page displays the specified authorization.)



Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
View Clinical Drafts
Claim Listing and Submission
Enter EAP CAF
Review Referrals
Enter Bed Tracking Information
Search Beds/Openings
EDI Homepage
Enter Member Reminders
On Track Outcomes
Reports
Print Spectrum Release of Information Form
My Online Profile
My Practice Information
Provider Data Sheet
Compliance
Handbooks
Forms
Network Specific Information
Education Center
ValueSelect Designation
Contact Us

Search Authorizations

Click the **View All** button below to see all authorizations regardless of effective and expiration dates. The Search Results screen will display all the authorizations. To search by effective and expiration date, enter the effective & expiration dates in the appropriate field and click on the **Search** button. The Search Results screen will display all the authorizations for the specified date range.

Required fields are denoted by an asterisk (*) adjacent to the label.
Please select a Provider ID below, to perform any one of the Authorization Search transactions below.

* Provider ID: 004058
NPI # for Authorization: Select...

Vendor ID:
Member ID:
Authorization #:
Client Authorization #:
Effective Date: 06/22/2012 (MMDDYYYY)
Expiration Date: 06/22/2013 (MMDDYYYY)
Only display EAP cases where final billing and/or disposition has not occurred. ☐

To search for and retrieve a downloadable authorization file listing within a specific date range, enter the desired activity From & To dates below, choose the delimiter type and click on the **Download** button.
Note: Please clear the effective and expiration date fields above in order to enable the download authorization function.

Activity Date span cannot exceed seven (7) days.
Activity Date Range can only be entered without a value in the Effective or Expiration Date fields above (or vice-versa).

Activity Date From:
Activity Date To:
Delimiter Type: ☐ Comma ',' ☐ Pipe '|'
View All **Search** **Download**

Figure 33: Search Authorizations

Refer to the [Review an Authorization - EAP CAF](#) chapter for detailed information about the *Search Results* section (including the Auth Summary, Auth Details, and Associated Claims tabs).

10

Enter an Authorization Request (RFS)

The *Enter an Authorization Request* function enables providers to electronically submit requests for services (RFS) for outpatient, inpatient, and medication management services. (This process is based on the member's contract.)

ProviderConnect sends automatic e-mail reminders to providers who have both saved drafts in RFS as well as saved a re-credentialing application draft. The e-mail reminder is sent 5 days after the last time the re-credentialing application draft was saved and 25 days after the RFS was saved.

An e-mail will be sent to each ProviderConnect user on the 6th day (after 5 days) after the last change date on an existing Provider Data Sheet (PDS) draft. An Authorization Request Draft Reminder e-mail will be sent to each ProviderConnect user (that is, the user who initially saved the draft) on the 26th day (after 25 days) after the initial save date on an existing Authorization (RFS) draft.

Draft reminder e-mails are not sent if a user does not have an e-mail address on file in the user's ProviderConnect account/profile record. Also, ProviderConnect sends reminder e-mails for only those RFS drafts that are in a "Saved" status, not in an "Expired" or a "Deleted" status.

Additionally, clinicians have the ability to electronically send a message to a provider's inbox with a request for any missing clinical information. The message, which is in the form of a web response, displays to the provider with a read-only history of the authorization request that was submitted by the provider and allows the provider an opportunity to respond back with the missing information within a defined turnaround time. The provider's feedback will be clinical information and will display in the CareConnect review. Providers can attach clinical documents and enter notes. Be aware however, that messages not responded to within the allotted time frame will be disabled.

Upon clicking [Enter an Authorization/Notification Request](#), the Disclaimer page displays.

1. Review the disclaimer.
2. Click **Next**.

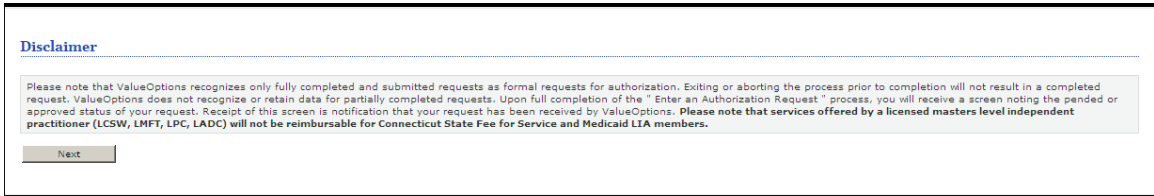


Figure 34: Disclaimer

Search a Member

The Search a Member page displays.

1. Enter the member ID in the **Member ID** field.
2. Enter a date in the **Date of Birth** field.

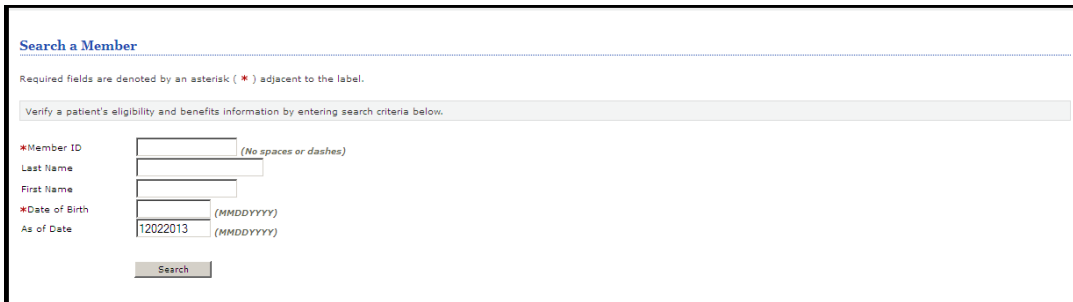


Figure 35: Search a Member

3. Enter the member's first and last names to narrow the search. (This step is optional.)
4. Click **Search**.

Review Demographics

The Demographics page displays.

1. Review the member's information.
2. Click **Next**.

Capture Provider

The Provider page displays.

1. Select the service address.
2. Click **Next**.

Enter Requested Services

The Requested Services Header page displays next. The level of service selected on this page determines which additional fields display and which pages need to be completed.

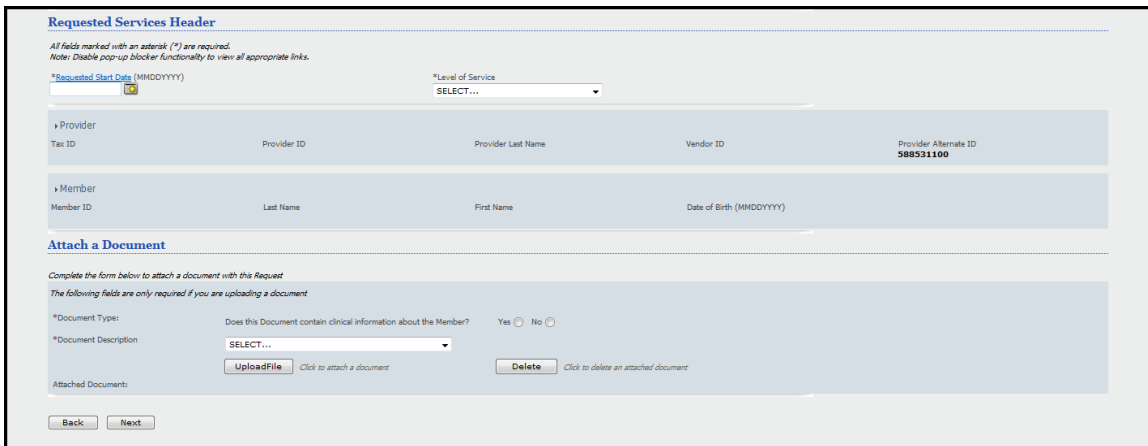
The three options for the level of service are:

- Outpatient
- Inpatient/HLOC/Specialty
- Medication Management

The steps for each level of service are covered in the following sections.



Instructions are provided for all the fields on a particular page. Only the fields with asterisks () are required, however.*



Requested Services Header

All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

*Requested Start Date (MMDDYYYY) *Level of Service

Provider
Tax ID Provider ID Provider Last Name Vendor ID Provider Alternate ID **58531100**

Member
Member ID Last Name First Name Date of Birth (MMDDYYYY)

Attach a Document

Complete the form below to attach a document with this Request
The following fields are only required if you are uploading a document

*Document Type: Does this Document contain clinical information about the Member? Yes ☐ No ☐

*Document Description

Click to attach a document Click to delete an attached document

Attached Document:

Figure 36: Requested Services Header

Outpatient Level of Service

Pages for either an ORF1 or an ORF2 display for the outpatient level of service depending on pre-established authorization parameters. In either case, you must enter a date in the **Requested Start Date** field.

Outpatient ORF1

If the outpatient request generates the equivalent of an ORF1 form, the following pages display.

- Type of Services
- Current Risks
- Requested Services
- Results



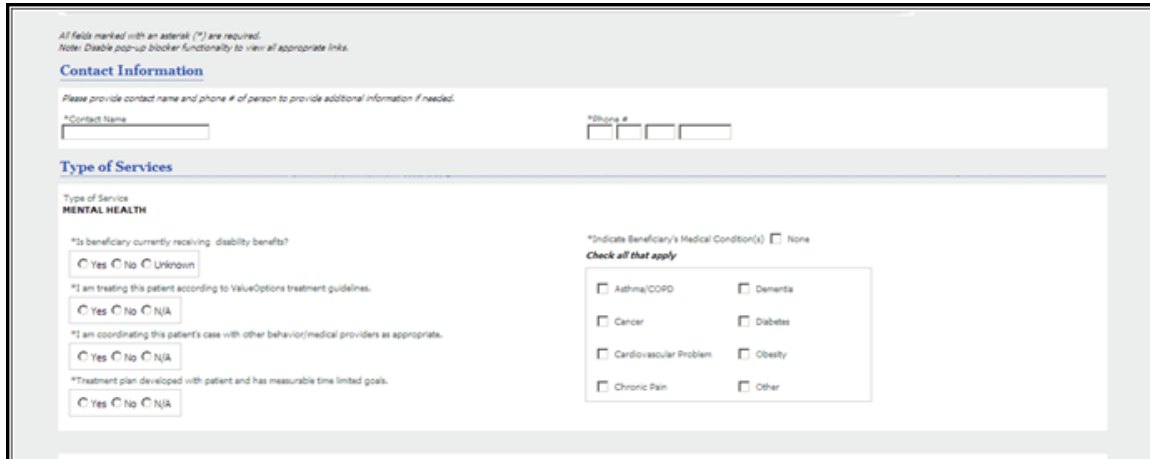
These pages need to be completed sequentially.

Only the fields with asterisks () are required.*

Type of Services

The Type of Services page is completed first.

1. Enter a **Contact Name** and **Phone Number**.
2. Answer the **Type of Services** questions.



All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

Contact Information

Please provide contact name and phone # of person to provide additional information if needed.

*Contact Name:

*Phone #:

Type of Services

Type of Service
MENTAL HEALTH

*Is beneficiary currently receiving disability benefits?
☐ Yes ☐ No ☐ Unknown

*I am treating this patient according to ValueOptions treatment guidelines.
☐ Yes ☐ No ☐ N/A

*I am coordinating this patient's case with other behavior/medical providers as appropriate.
☐ Yes ☐ No ☐ N/A

*Treatment plan developed with patient and has measurable time limited goals.
☐ Yes ☐ No ☐ N/A

*Indicate Beneficiary's Medical Condition(s) ☐ None
Check all that apply

<input type="checkbox"/> Asthma/COPD	<input type="checkbox"/> Dementia
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Cardiovascular Problem	<input type="checkbox"/> Obesity
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Other

Figure 37: Type of Services

3. Enter the member's diagnosis information. (Refer to the [Diagnosis](#) section under [Outpatient ORF2](#) authorization requests.)

Diagnosis

Documentation of **primary behavioral condition** is required. Provisional working condition and diagnosis should be documented if necessary. Documentation of **secondary co-occurring behavioral conditions** that impact or are a focus of treatment (mental health, substance use, personality, intellectual disability) is **strongly recommended** to support comprehensive care. Authorization (if applicable) does NOT guarantee payment of benefits for these services. Coverage is subject to all limits and exclusions outlined in the member's plan and/or summary plan description including covered diagnoses.

Behavioral Diagnoses

Primary Behavioral Diagnosis

*Diagnostic Category 1 *Diagnosis Code 1 *Description

Additional Behavioral Diagnoses

Diagnostic Category 2 Diagnosis Code 2 Description

Diagnostic Category 3 Diagnosis Code 3 Description

Diagnostic Category 4 Diagnosis Code 4 Description

Diagnostic Category 5 Diagnosis Code 5 Description

Primary Medical Diagnoses

Primary medical diagnosis is required. Select primary medical diagnostic category from dropdown or select medical diagnosis code and description.

*Diagnostic Category 1 Diagnosis Code 1 Description

Diagnostic Category 2 Diagnosis Code 2 Description

Diagnostic Category 3 Diagnosis Code 3 Description

Social Elements Impacting Diagnosis

*Check all that apply

☐ None ☐ Problems with access to health care services ☐ Housing problems (Not Homelessness) ☐ Problems related to the social environment

☐ Educational problems ☐ Problems related to interaction w/legal system/crime ☐ Occupational problems ☐ Homelessness

☐ Financial problems ☐ Problems with primary support group ☐ Other psychosocial and environmental problems ☐ Unknown

Functional Assessment

Please indicate the functional assessment tool utilized or select Other to write in other specific tool. Assessment score for specific tool should be noted in the Assessment Score field.

Assessment Measure Assessment Score Secondary Assessment Measure Assessment Score

Figure 38: Diagnosis

Current Risks

The Current Risks page displays next.

1. Enter a rating in the **Member's Risk to Self** field.
2. Enter a rating in the **Member's Risk to Others** field.

All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

Current Risks

Key:
0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

*Beneficiary's Risk to Self *Beneficiary's Risk to Others

0 0 1 0 2 0 3 0 N/A 0 0 1 0 2 0 3 0 N/A

Figure 39: Current Risks

Click the links to display the rating information windows.

In the Current Impairments section:

1. Rate the severity of each of the listed impairments.
2. Click **Next**.

All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

Current Impairments

Key:
0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

*Mood Disturbances (Depression or Mania)	*Weight Change Associated with a Behavioral Diagnosis
<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A
*Anxiety	*Medical/ Physical Conditions
<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A
*Psychosis/ Hallucinations/ Delusions	*Substance Abuse/ Dependence
<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A
*Thinking/ Cognition/ Memory/ Concentration Problems	*Job/ School Performance Problems
<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A
*Impulsive/ Reckless/ Aggressive Behavior	*Social Functioning/ Relationships/ Marital/ Family Problems
<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A
*Activities of Daily Living Problems	*Legal
<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A

Figure 40: Current Impairments

3. Either **Accept** or **Reject** the number of visits.

Requested Services

The Requested Services page displays next.

1. Select an option from the **Place of Service** drop-down.
2. Click **Add/Modify Service Classes** and select the appropriate service class from the list. (Up to 20 service classes can be selected.)

The number of visits/units auto-populate. If more than one service is requested:

1. Enter information on additional lines.
2. Enter the number of visits in the **Visits/Units** field.
3. Go back and modify the **Visits/Units** field in the previous line so that the **Total Visits/Units** amount does not exceed the allowed amount.
4. Click **Submit**.

Clicking **Next** on the Requested Services page redirects the user to the Determination Status page. (If needed, refer to the [Decrease Approved Visits](#) section at the end of this chapter for detailed information about how to decrease the number of approved visits.)

Outpatient ORF2

If the outpatient request generates the equivalent of an ORF2 form, the following several pages display. (The Requested Services page may or may not display depending on pre-established parameters.)

- Type of Services
- Current Risks
- Diagnosis
- Treatment History
- Treatment Plan
- Psychotropic Medications
- Requested Services
- Results

Type of Services

The Type of Services page is completed first.

1. Enter the **Contact Name** and **Phone Number** of the person to be contacted if additional information is needed.
2. Enter a name, if applicable, in the **Member's Guardian** field.
3. Select an option in the **Is member currently receiving disability benefits?** field and click **Next**.

Current Risks

The Current Risks page displays next.

1. Enter a rating in the **Member's Risk to Self** field.
2. Enter a rating in the **Member's Risk to Others** field.

Click the links to display the rating information windows.



All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

Current Risks

Key:
0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

*Beneficiary's Risk to Self

0 1 2 3 N/A

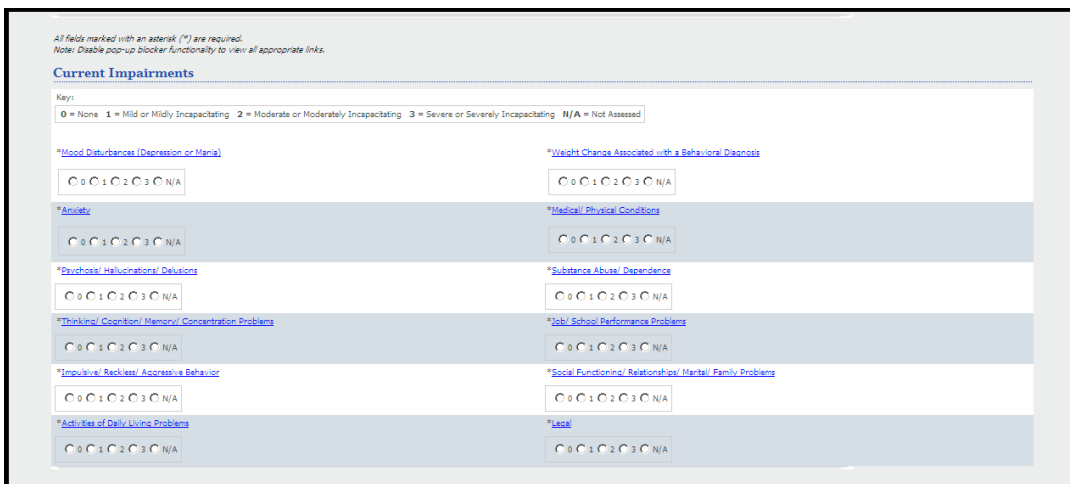
*Beneficiary's Risk to Others

0 1 2 3 N/A

Figure 41: Current Risks

In the Current Impairments section:

1. Rate the severity of each of the listed impairments.
2. Click **Next**.



All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

Current Impairments

Key:
0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

*Mood Disturbances (Depression or Mania)	*Weight Change Associated with a Behavioral Diagnosis
0 1 2 3 N/A	0 1 2 3 N/A
*Anxiety	*Medical/Physical Conditions
0 1 2 3 N/A	0 1 2 3 N/A
*Psychosis/Hallucinations/Delusions	*Substance Abuse/Dependence
0 1 2 3 N/A	0 1 2 3 N/A
*Thinking/Coordination/Memory/Concentration Problems	*Job/School Performance Problems
0 1 2 3 N/A	0 1 2 3 N/A
*Impulsive/Reckless/Accrative Behavior	*Social Functioning/Relationships/Marital/Family Problems
0 1 2 3 N/A	0 1 2 3 N/A
*Activities of Daily Living Problems	*Legal
0 1 2 3 N/A	0 1 2 3 N/A

Figure 42: Current Impairments



Diagnosis

The Diagnosis page displays next and contains the following sections for capturing diagnosis information.

- [Behavioral Diagnoses](#)
- [Primary Medical Diagnoses](#)
- [Social Elements Impacting Diagnosis](#)
- [Functional Assessment](#)

Behavioral Diagnoses

The *Behavioral Diagnoses* section contains five rows for capturing diagnoses. Each row contains the following fields.

- Diagnostic Category
- Diagnosis Code
- Description

The system uses the value entered in the **Diagnostic Category** field to determine the values of the other two fields. If multiple options are available for the remaining fields, the user can select from among a list of possible choices. If only one option is available for the remaining fields, the system auto-populates those values.



Entering either a diagnosis code or description automatically populates the other two fields if only one description exists for that particular code or vice versa.

This section functions as follows:

- Users may enter up to five diagnoses, **but only the principal (primary) diagnosis is required.**
- All the fields are required as all three fields are needed to obtain a complete behavioral diagnosis.
- The user must enter at least three characters of the diagnosis code in order to initiate the automatic search. (That is, the automatic search begins when the fourth character is entered.)
- Upon a user entering a partial or complete diagnosis description and then tabbing or clicking out of the field, the system begins an automatic search to complete the other two fields if there is only a single match

Primary Medical Diagnoses

The *Primary Medical Diagnoses* section contains three rows for capturing diagnoses. Each row contains the following fields.

- Diagnostic Category
- Diagnosis Code
- Description

The system uses the value entered in the **Diagnostic Category** field to determine the values of the other two fields. If multiple options are available for the remaining fields, the user can select from among a list of possible choices. If only one option is available for the remaining fields, the system auto-populates those values.



Entering either a diagnosis code or description automatically populates the other two fields if only one description exists for that particular code or vice versa.

This section functions as follows:

- Users may enter up to three diagnoses, **but only the principal (primary) diagnosis is required.**
- The diagnosis code and description are optional.
- The user must enter at least two characters of the diagnosis code in order to initiate the automatic search. (That is, the automatic search begins when the third character is entered.)
- Upon a user entering a partial or complete diagnosis description and then tabbing or clicking out of the field, the system begins an automatic search to complete the other two fields if there is only a single match.

Social Elements Impacting Diagnosis

The *Social Elements Impacting Diagnosis* section contains the following checkboxes. (Users may select multiple checkboxes, but are required to select at least one.)

- None
- Educational problems
- Financial problems
- Housing Problems (Not Homelessness)
- Homelessness
- Occupational problems
- Problems with Primary support group
- Problems with access to health care services
- Problems related to interaction w/legal system/crime
- Problems related to the social environment
- Other psychosocial and environmental problems*
- Unknown

*Selecting **Other psychosocial and environmental problems** activates a 250-character text box. (This field is required.)

Functional Assessment

The *Functional Assessment* section contains the following fields.

- Assessment Measure
- Secondary Assessment Measure

The following options are available in both drop-downs.

- CDC HRQOL
- FAST
- GAF
- Other*
- OMFAQ
- SF12
- SF36
- WHO DAS

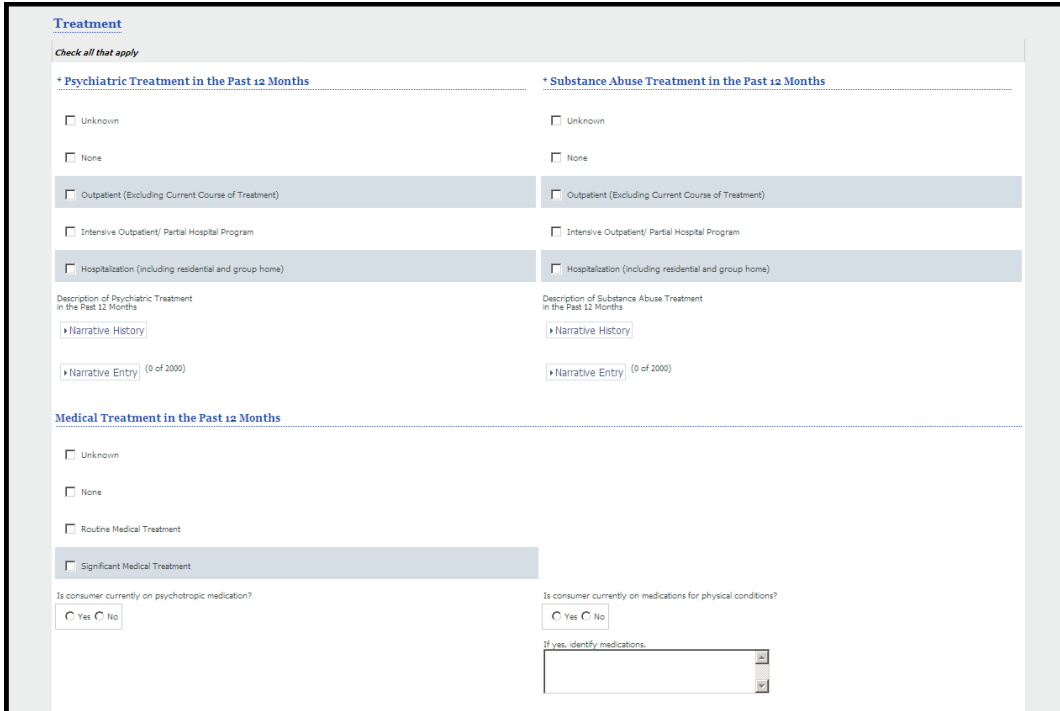
*Selecting **Other** from either drop-down activates a 25-character text box. (This field is required.)

The system also displays an **Assessment Score** field next to each assessment measure. These fields accept a maximum of 25 alphanumeric characters and are required for each assessment measure selected.

Treatment History

The Treatment History page displays next.

1. Complete the Psychiatric Treatment in the Past 12 Months section.
2. Complete the Substance Abuse Treatment in the Past 12 Months section.
3. Complete the Medical Treatment in the Past 12 Months section.
4. Click **Next**.



Treatment

Check all that apply

*** Psychiatric Treatment in the Past 12 Months**

☐ Unknown

☐ None

☐ Outpatient (Excluding Current Course of Treatment)

☐ Intensive Outpatient/ Partial Hospital Program

☐ Hospitalization (including residential and group home)

Description of Psychiatric Treatment in the Past 12 Months

▶ Narrative History

▶ Narrative Entry (0 of 2000)

*** Substance Abuse Treatment in the Past 12 Months**

☐ Unknown

☐ None

☐ Outpatient (Excluding Current Course of Treatment)

☐ Intensive Outpatient/ Partial Hospital Program

☐ Hospitalization (including residential and group home)

Description of Substance Abuse Treatment in the Past 12 Months

▶ Narrative History

▶ Narrative Entry (0 of 2000)

Medical Treatment in the Past 12 Months

☐ Unknown

☐ None

☐ Routine Medical Treatment

☐ Significant Medical Treatment

Is consumer currently on psychotropic medication?

☐ Yes ☐ No

Is consumer currently on medications for physical conditions?

☐ Yes ☐ No

If yes, identify medications.

Figure 43: Treatment History



If any of the blue highlighted options are selected, additional fields display that must be completed.

Treatment Plan

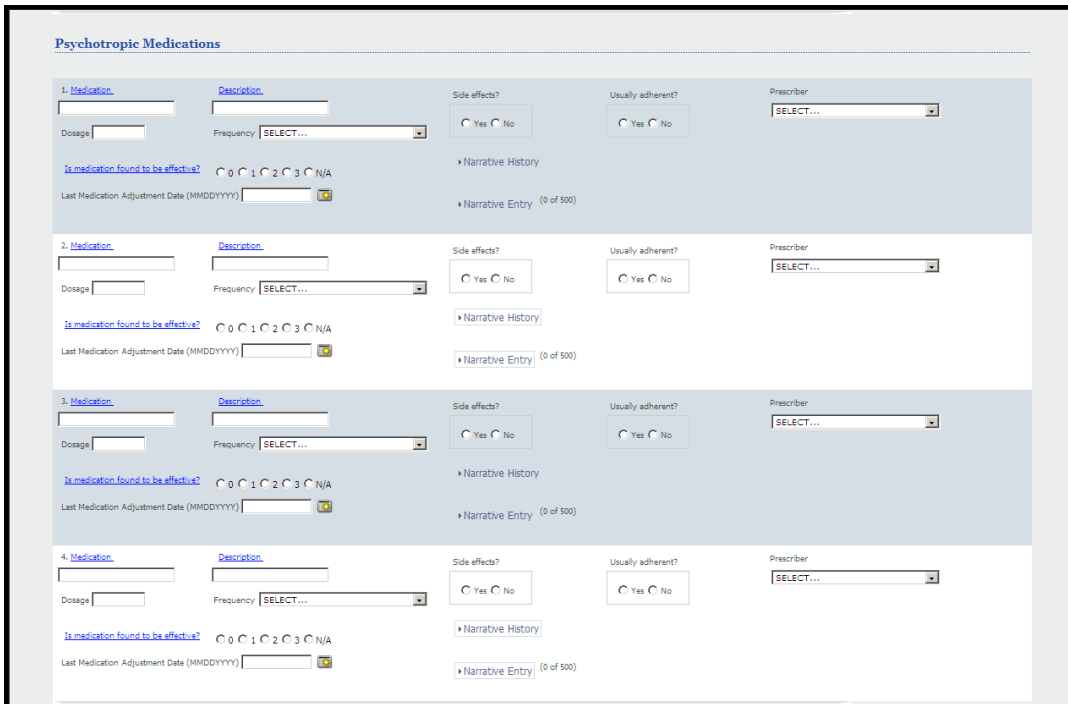
Information can be entered on the Treatment Plan page if applicable.

1. Complete all the fields that apply.
2. Complete the required questions **I am treating this member according to Beacon Health Options treatment guidelines** and **Treatment plan developed with member and has measureable time limited goals**.
3. Click **Next**.

Psychotropic Medications

Information must now be entered on the Psychotropic Medications page.

1. Enter the medication's name in the **Medication** field or click on the link to select a medication.
2. Enter the amount in the **Dosage** field.
3. Select an option from the **Frequency** drop-down.
4. Select either **Yes** or **No** in the **Side Effects** field.
5. Select either **Yes** or **No** in the **Usually adherent** field.
6. Select an option from the **Prescriber** drop-down.
7. Repeat steps 1 through 6 for each additional medication and click **Next**.



The screenshot displays the 'Psychotropic Medications' form, which contains four identical sections for entering medication information. Each section includes the following fields and options:

- 1. Medication:** A text input field with a link 'Is medication found to be effective?' below it.
- Description:** A text input field.
- Dosage:** A text input field.
- Frequency:** A drop-down menu with 'SELECT...' as the current selection.
- Side effects?:** Radio buttons for 'Yes' and 'No'.
- Usually adherent?:** Radio buttons for 'Yes' and 'No'.
- Prescriber:** A drop-down menu with 'SELECT...' as the current selection.
- Last Medication Adjustment Date (MMDDYYYY):** A date input field with a calendar icon.
- Narrative History:** A link to view history.
- Narrative Entry:** A text area with a character count '(0 of 500)'.

Figure 44: Psychotropic Medications



Click on the [Medication](#) link to display the Select Medication Code window.

Requested Services

The Requested Services tab may display next.

1. Select an option from the **Place of Service** drop-down.
2. Click **Add/Modify Service Classes** and select the appropriate service class from the list.

Note: *Up to 20 service classes can be selected.*

3. Click **Submit**.

The number of visits/units auto-populate. If more than one service is requested:

1. Enter information on additional lines.
2. Enter the number of visits in the **Visits/Units** field.
3. Go back and modify the **Visits/Units** field in the previous line so that the **Total Visits/Units** amount does not exceed the allowed amount.
4. Click **Submit**.

Clicking **Next** on the Requested Services page redirects the user to the Determination Status page. (If needed, refer to the [Decrease Approved Visits](#) section at the end of this chapter for detailed information about how to decrease the number of approved visits.)

Inpatient/HLOC/Specialty Level of Service – ITR Form

For an Inpatient/HLOC/Specialty Level of Service using the Inpatient Treatment Report (ITR) form:

1. Enter a date in the **Requested Start Date** field.
2. Select **Inpatient/HLOC/Specialty** from the **Level of Service** drop-down.
3. Select an option from the **Type of Service** drop-down.
4. Select an option from the **Level of Care** drop-down.
5. Select an option from the **Type of Care** drop-down.
6. Enter a date in the **Admit Date** field.
7. Enter a time in the **Admit Time** field.
8. Select either **Yes** or **No** in the **Has the member already been admitted to the facility?** field.

Note:

- *This question displays only if the level of service is Inpatient/HLOC/Specialty.*
- *This question is required if the level of service is Inpatient/HLOC/Specialty and any combination of type of service, level of care, and type of care is selected.*

9. Attach any applicable documents and click **Next**.

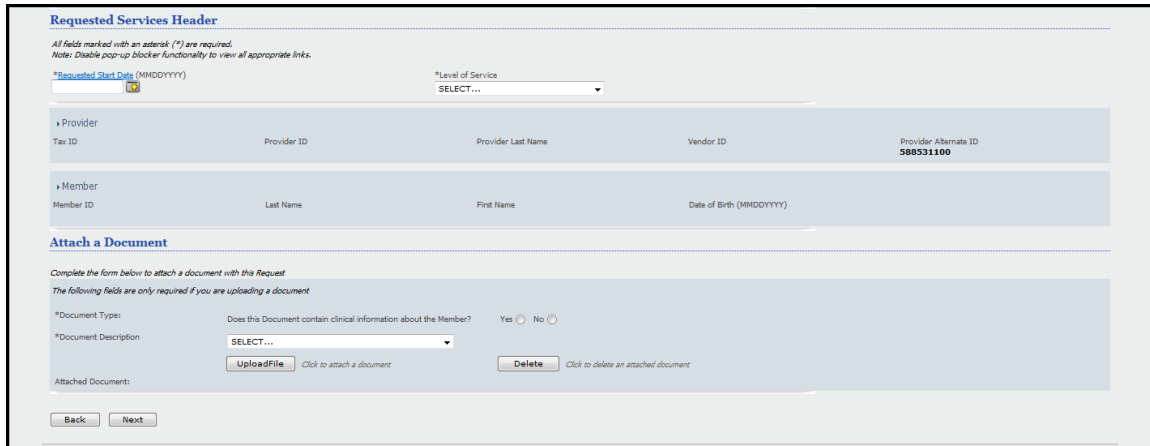


Figure 45: Requested Services Header



A page containing several tabs displays.

Only the fields with asterisks (*) are required.

Level of Care

The Level of Care page is completed first.

1. Verify the level of care and type of service.
2. Enter the treatment in the **Treatment Unit/Program** field.
3. Enter a name in the **Member's Guardian** field.
4. Select an option from the **Member's Current Location** drop-down.
5. Select an option from the **Primary Referral Source** drop-down.
6. Enter an aftercare follow-up phone number.

-or-

Select **N/A** and enter a reason.



Figure 46: Level of Care – Preliminary Information

7. Enter at least one contact name and phone number and click **Next**.

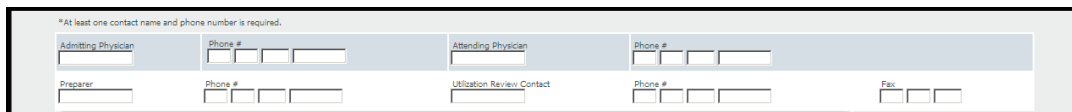
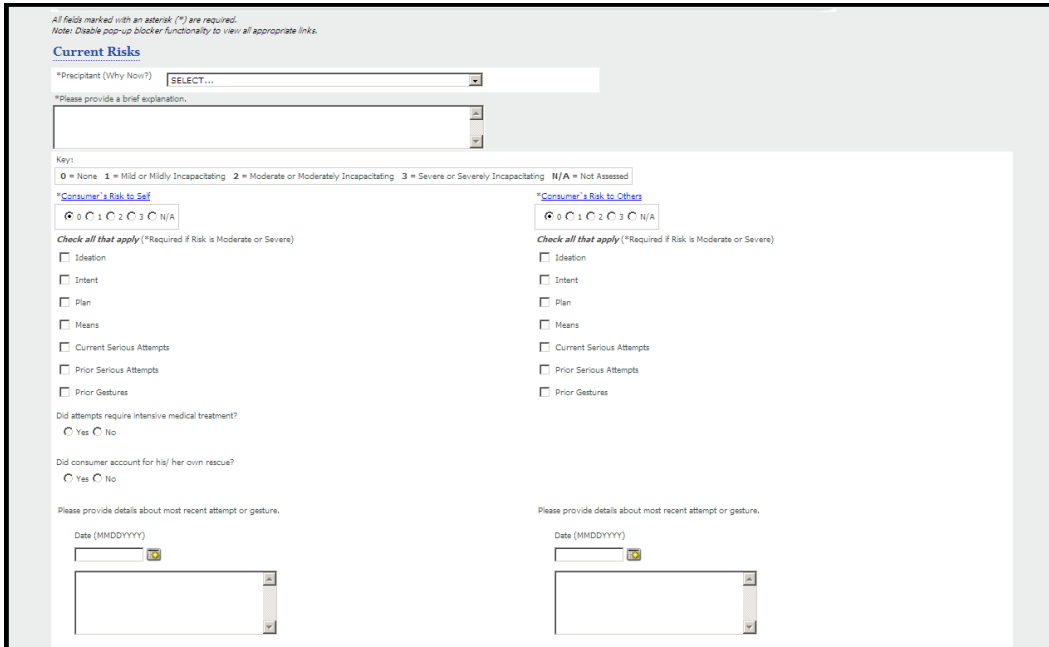


Figure 47: Level of Care – Contact Information

Current Risks

The Currents Risks page displays next.

1. Select an option from the **Precipitant (Why Now?)** drop-down and enter a brief explanation.
2. Complete the Member's Risk to Self section.
3. Complete the Member's Risk to Others section.
4. Click **Next**.



The screenshot shows the 'Current Risks' form. At the top, it states: 'All fields marked with an asterisk (*) are required. Note: Disable pop-up blocker functionality to view all appropriate links.' Below this is the 'Current Risks' title. The first section is '*Precipitant (Why Now?)' with a 'SELECT...' dropdown and a text area for 'Please provide a brief explanation.' Below this is a 'Key:' section with a legend: '0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed'. The form is divided into two main sections: '*Consumer's Risk to Self' and '*Consumer's Risk to Others'. Each section has a radio button selection for 0, 1, 2, 3, or N/A. Below each selection is a 'Check all that apply' section with checkboxes for: Ideation, Intent, Plan, Means, Current Serious Attempts, Prior Serious Attempts, and Prior Gestures. There are also two questions: 'Did attempts require intensive medical treatment?' and 'Did consumer account for his/ her own rescue?', each with 'Yes' and 'No' radio buttons. At the bottom of each section is a text area for 'Please provide details about most recent attempt or gesture.' and a date field labeled 'Date (MM/DD/YYYY)'.

Figure 48: Current Risks

Current Impairments

The Current Impairments page displays next.

1. Rate the severity of each of the listed impairments.
2. Click **Next**.

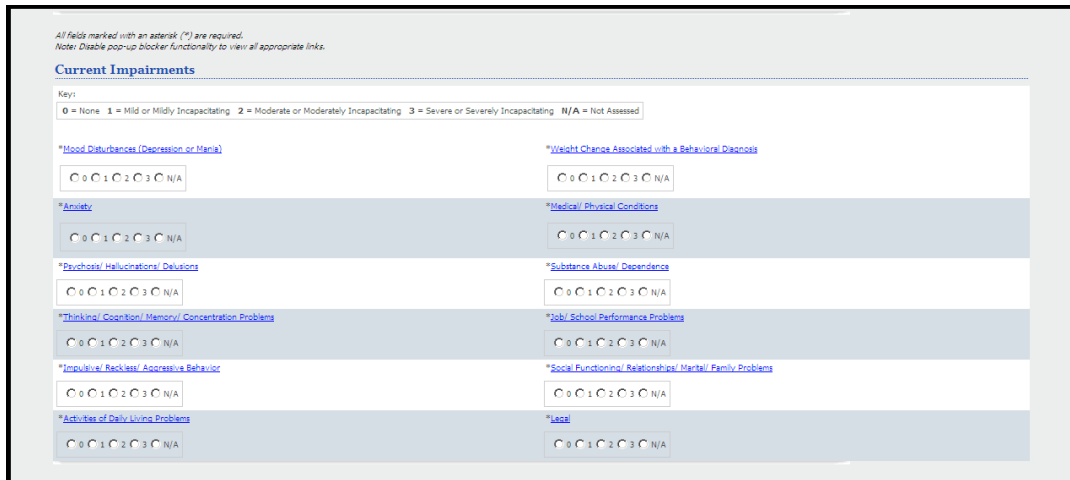


Figure 49: Current Impairments

Diagnosis

The Diagnosis page displays next and contains the following sections for capturing diagnosis information.

- [Behavioral Diagnoses](#)
- [Primary Medical Diagnoses](#)
- [Social Elements Impacting Diagnosis](#)
- [Functional Assessment](#)

Behavioral Diagnoses

The *Behavioral Diagnoses* section contains five rows for capturing diagnoses. Each row contains the following fields.

- Diagnostic Category
- Diagnosis Code
- Description

The system uses the value entered in the **Diagnostic Category** field to determine the values of the other two fields. If multiple options are available for the remaining fields, the user can select from among a list of possible choices. If only one option is available for the remaining fields, the system auto-populates those values.



Entering either a diagnosis code or description automatically populates the other two fields if only one description exists for that particular code or vice versa.

This section functions as follows:

- Users may enter up to five diagnoses, **but only the principal (primary) diagnosis is required.**
- All the fields are required as all three fields are needed to obtain a complete behavioral diagnosis.
- The user must enter at least three characters of the diagnosis code in order to initiate the automatic search. (That is, the automatic search begins when the fourth character is entered.)
- Upon a user entering a partial or complete diagnosis description and then tabbing or clicking out of the field, the system begins an automatic search to complete the other two fields if there is only a single match

Primary Medical Diagnoses

The *Primary Medical Diagnoses* section contains three rows for capturing diagnoses. Each row contains the following fields.

- Diagnostic Category
- Diagnosis Code
- Description

The system uses the value entered in the **Diagnostic Category** field to determine the values of the other two fields. If multiple options are available for the remaining fields, the user can select from among a list of possible choices. If only one option is available for the remaining fields, the system auto-populates those values.



Entering either a diagnosis code or description automatically populates the other two fields if only one description exists for that particular code or vice versa.

This section functions as follows:

- Users may enter up to three diagnoses, **but only the principal (primary) diagnosis is required.**
- The diagnosis code and description are optional.
- The user must enter at least two characters of the diagnosis code in order to initiate the automatic search. (That is, the automatic search begins when the third character is entered.)
- Upon a user entering a partial or complete diagnosis description and then tabbing or clicking out of the field, the system begins an automatic search to complete the other two fields if there is only a single match.

Social Elements Impacting Diagnosis

The *Social Elements Impacting Diagnosis* section contains the following checkboxes. (Users may select multiple checkboxes, but are required to select at least one.)

- None
- Educational problems
- Financial problems
- Housing Problems (Not Homelessness)

- Homelessness
- Occupational problems
- Problems with Primary support group
- Problems with access to health care services
- Problems related to interaction w/legal system/crime
- Problems related to the social environment
- Other psychosocial and environmental problems*
- Medical disabilities that impact diagnosis or must be accommodated for in treatment
- Unknown

*Selecting **Other psychosocial and environmental problems** activates a 250-character text box. (This field is required.)

Functional Assessment

The *Functional Assessment* section contains the following fields.

- Assessment Measure
- Secondary Assessment Measure

The following options are available in both drop-downs.

- CDC HRQOL
- FAST
- GAF
- Other*
- OMFAQ
- SF12
- SF36
- WHO DAS

*Selecting **Other** from either drop-down activates a 25-character text box. (This field is required.)

The system also displays an **Assessment Score** field next to each assessment measure. These fields accept a maximum of 25 alphanumeric characters and are required for each assessment measure selected.

Treatment History

The Treatment History page displays next.

1. Complete the Psychiatric Treatment in the Past 12 Months section.
2. Complete the Substance Abuse Treatment in the Past 12 Months section.
3. Complete the Medical Treatment in the Past 12 Months section if needed.
4. Click **Next**.

Treatment

Check all that apply

* Psychiatric Treatment in the Past 12 Months

☐ Unknown
 ☐ None
 ☒ Outpatient (Excluding Current Course of Treatment)
 ☐ Intensive Outpatient/ Partial Hospital Program
 ☐ Hospitalization (including residential and group home)

Description of Psychiatric Treatment in the Past 12 Months

* Substance Abuse Treatment in the Past 12 Months

☐ Unknown
 ☐ None
 ☒ Outpatient (Excluding Current Course of Treatment)
 ☐ Intensive Outpatient/ Partial Hospital Program
 ☐ Hospitalization (including residential and group home)

Description of Substance Abuse Treatment in the Past 12 Months

Medical Treatment in the Past 12 Months

☐ Unknown
 ☐ None
 ☐ Routine Medical Treatment
 ☒ Significant Medical Treatment

Is consumer currently on psychotropic medication?

☐ Yes ☒ No

Is consumer currently on medications for physical conditions?

☐ Yes ☒ No

If yes, identify medications.

Figure 50: Treatment History

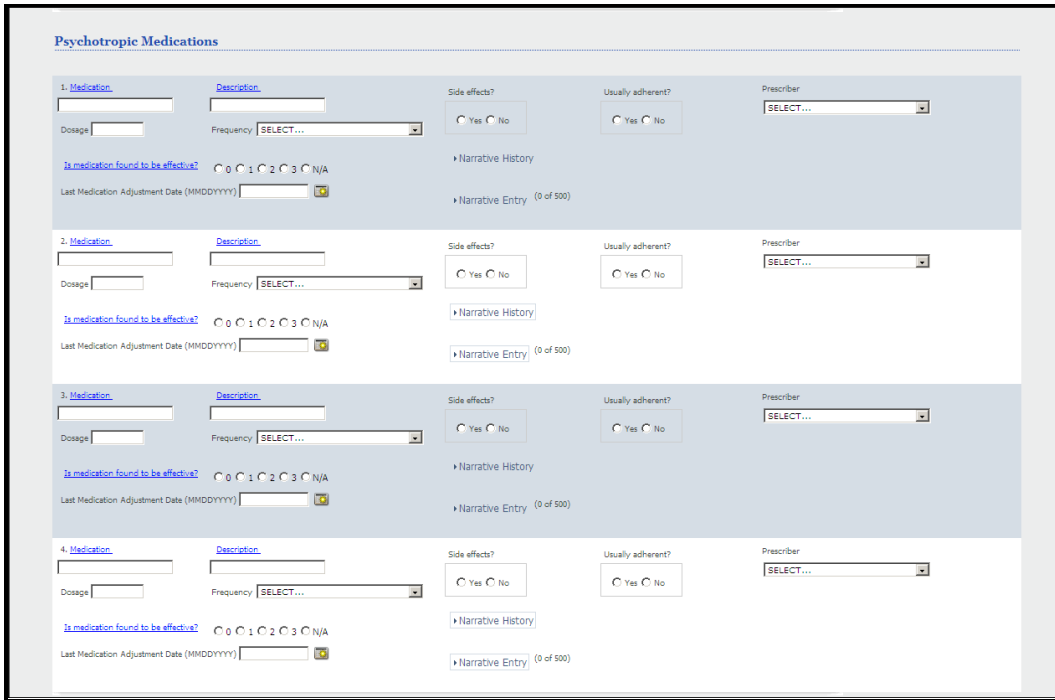
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Psychotropic Medications

The Psychotropic Medications page displays next.

1. Enter the medication's name in the **Medication** field or click on the link to select a medication.
2. Enter the amount in the **Dosage** field.
3. Select an option from the **Frequency** drop-down.
4. Select either **Yes** or **No** in the **Side Effects** field.
5. Select either **Yes** or **No** in the **Usually Adherent** field.
6. Select an option from the **Prescriber** drop-down.
7. Repeat steps 1 through 6 for each additional medication and click **Next**.



The screenshot displays the 'Psychotropic Medications' form, which contains four identical sections for entering medication information. Each section includes the following fields and controls:


- Medication:** A text input field with a link 'In medication found to be effective?' below it.
- Description:** A text input field.
- Dosage:** A text input field.
- Frequency:** A drop-down menu with 'SELECT...' as the placeholder.
- Side effects?:** Radio buttons for 'Yes' and 'No'.
- Usually adherent?:** Radio buttons for 'Yes' and 'No'.
- Prescriber:** A drop-down menu with 'SELECT...' as the placeholder.
- Last Medication Adjustment Date (MMDDYYYY):** A date input field with a calendar icon.
- Narrative History:** A link to view history.
- Narrative Entry:** A text area with a character count '(0 of 500)'.

Figure 51: Psychotropic Medications

Substance Abuse

The Substance Abuse page displays next.

1. Check all **Substance Abuse** types that apply.



All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

Substance Abuse

Check all that apply.
At least one substance must be selected

- ☐ Alcohol
- ☐ Amphetamines/ Stimulants (diet pills, "speed", Ecstasy, Ritalin, etc.)
- ☐ Barbiturates (sedatives, "downers", etc.)
- ☐ Cocaine (crack, powder, etc.)
- ☐ Hallucinogens (LSD, mescaline, etc.)
- ☐ Inhalants (glue, gasoline, solvents, nitrites, etc.)
- ☐ Marijuana or Hashish
- ☐ Opioids (Heroin, Morphine, etc.)
- ☐ Over-the-counter Cold or Cough Medications (dextromethorphan, etc.)
- ☐ PCP (Phencyclidine)
- ☐ Pain Killers (Codeine, Demerol, etc.)
- ☐ Sleeping Pills
- ☐ Steroids
- ☐ Tranquilizers (Valium, Xanax, other anxiolytics, etc.)
- ☐ Other Prescription Drugs
- ☐ Other Non-prescription Drugs or Substances
- ☐ Unknown

Substance Abuse Details

▶ Narrative History

▶ Narrative Entry (0 of 500)

Figure 52: Substance Abuse Types

For each substance you selected:

- Select an option from the **Total Years of Use** drop-down.
 - Select an option from the **Length of Current Use** drop-down.
 - Enter an amount in the **Amount of Use** field.
 - Select an option from the **Frequency of Use** drop-down.
 - Enter a date in the **Date Last Used** field.
2. Select all **Withdrawal Symptoms** that the member is experiencing.

Note: This field is required if the type of service is **Detoxification**.
 3. Complete the Vitals section (i.e., Blood Pressure, Temperature, Pulse, Respiration, and Blood Alcohol).

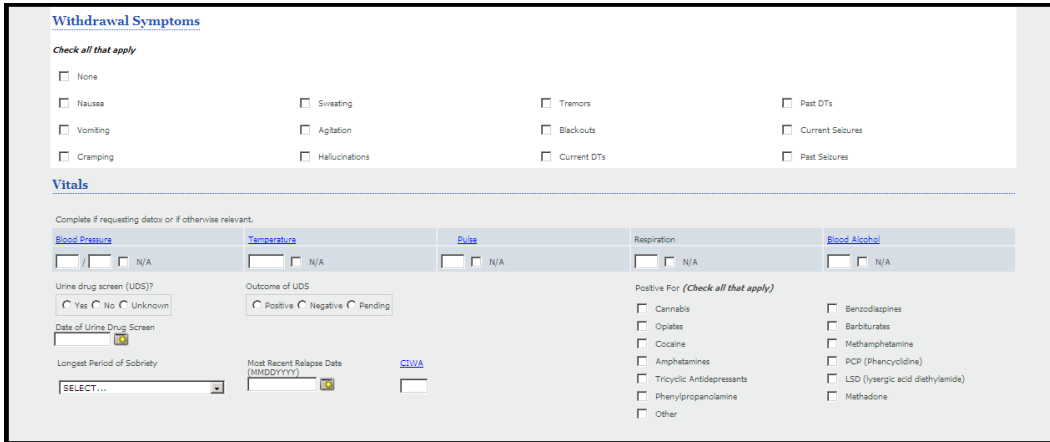


Figure 53: Withdrawal Symptoms and Vitals

The ASAM/Other Patient Placement Criteria section must be completed next.

1. Select **Low**, **Medium**, or **High** for the **Dimension 1**, **Dimension 2**, and **Dimension 3** fields if the type of service is **Detoxification**.
2. Select **Low**, **Medium**, or **High** for the **Dimension 1** through **Dimension 6** fields if the type of service is **Substance Abuse** and click **Next**.



Figure 54: ASAM/Other Placement Criteria

Treatment Plan

The Treatment Plan page displays next.

1. Enter the **Date of Plan**.
2. Select either **Yes** or **No** in the **Member/Guardian Involved in Treatment Plan** field.
3. Expand the **PCP for Select Medicaid Accounts** section if applicable.
4. Enter **Long Term Goals**.
5. Enter information in the **Symptom/Observation** text box and all applicable text boxes in that section. (Sections repeat for multiple symptoms to be entered.)

All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

Treatment Plan

Date of Plan Date (MMDDYYYY) Consumer/Guardian involved in Treatment plan? ☐ Yes ☐ No

Long Term Goal (0 of 250)

[PCP for Select Medicaid Accounts](#)

Discharge Transition Plan Supports in Place *Has ACS Provider Been Contacted? ☐ Yes ☐ No

(0 of 500)

1. Symptom/Observation Target Date (MMDDYYYY)

Status of Objective

(0 of 250)

Short Term Objective

(0 of 250)

Intervention

(0 of 250)

2. Symptom/Observation Target Date (MMDDYYYY)

Status of Objective

(0 of 250)

Short Term Objective

(0 of 250)

Date Revised (MMDDYYYY)

Revision History Status of Objective Date Revised

Figure 55: Treatment Plan

Treatment Request

The Treatment Request page displays next.

1. Select either **Yes** or **No** in the **Certificate of Need Required** field.
2. Select either **Yes** or **No** in the **Is Family/Couples Therapy Indicated** field.
3. Expand the **Medical Implications** section if applicable.
4. Check all boxes that apply for the **Treatment Request Information** fields.
5. Enter the length in the **Specify Length** field if the Fixed Length Program option is selected.
6. Enter a number (of visits per week or days per month) if the Frequency of Program option is selected.
7. Select an option from the **Primary Reason for Continued Stay** drop-down.
8. Select an option from the **Primary Barrier to Discharge** drop-down.

All fields marked with an asterisk () are required.
Note: Disable pop-up blocker functionality to view all appropriate links.*

Treatment Request

Admit Date: 06/13/2013 [Certificate of need required?](#)
☐ Yes ☐ No

Is family/couples therapy indicated?
☐ Yes ☐ No

Medical Implications

Check all that apply

Treatment Request Information

<input type="checkbox"/> Involuntary Admission	<input type="checkbox"/> Court Ordered	Treatment Includes <input type="checkbox"/> ECT <input type="checkbox"/> Psych Testing (Separate pre-authorization may be required.)
<input type="checkbox"/> Voluntary Admission	<input type="checkbox"/> Frequency of Program	
<input type="checkbox"/> Fixed Length Program		

Specify Length: per

*Was consumer referred to State Facility?
☐ Yes ☐ No

Check all that apply

If Admitted or Transferred, Reasons for Admission or Transfer

<input type="checkbox"/> Extended Length Of Stay Anticipated	<input type="checkbox"/> CHIPS Hospital Refused
<input type="checkbox"/> No CHIPS Bed Available	<input type="checkbox"/> Dual Diagnosis
<input type="checkbox"/> Multiple Prior Admissions	<input type="checkbox"/> Failure to Stabilize
<input type="checkbox"/> Homeless	<input type="checkbox"/> Other: <input type="text"/>

Primary Reason for Continued Stay
 SELECT...

Primary Barrier to Discharge
 SELECT...

Explanation for Continued Stay

► Narrative History

► Narrative Entry (0 of 250)

Figure 56: Treatment Request

9. Check all applicable **Baseline Functioning** behaviors. Describe the behavior in the text box if **Other** is checked.
10. Enter a date in the **Expected Discharge Date** field.
11. Enter a date in the **Estimated Return to Work Date** field.

-OR-

Select **N/A** if the information is not available.

12. Select an option from the **Planned Discharge Level of Care** drop-down.
13. Select an option from the **Planned Discharge Residence** drop-down.
14. Click **Submit**.

Baseline Functioning

<input type="checkbox"/> Holds Job	<input type="checkbox"/> Functions Independently/ ADLs Satisfactory
<input type="checkbox"/> Asymptomatic	<input type="checkbox"/> Abolinent
<input type="checkbox"/> Manages Medications/ Medication Compliant	<input type="checkbox"/> Other: <input type="text"/>

Expected Discharge Date (MMDDYYYY)

Estimated Return to Work Date (MMDDYYYY)
 ☐ N/A

*Planned Discharge Level of Care
 SELECT...

*Planned Discharge Residence
 SELECT...

If Planned Discharge Residence is "State Hospital"
 SELECT...

Back Submit

Figure 57: Baseline Functioning

The Determination Status page displays next.

Inpatient/HLOC/Specialty Level of Service – ITR2 Form

The IP/HLOC Inpatient Treatment Report (ITR2) form is designed to encourage more provider use of ProviderConnect.

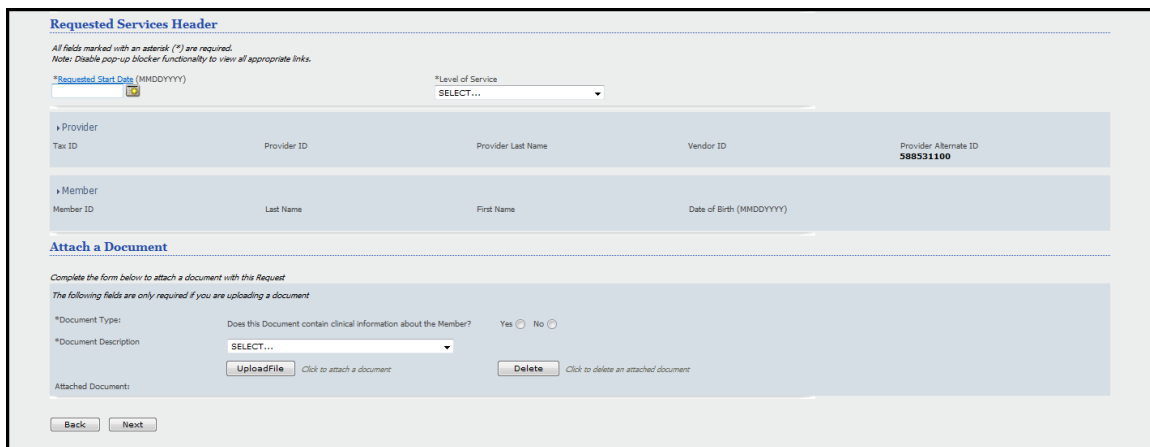
For an Inpatient/HLOC/Specialty Level of Service using the Inpatient Treatment Report (ITR2) form:

1. Enter a date in the **Requested Start Date** field.
2. Select **Inpatient/HLOC/Specialty** from the **Level of Service** drop-down.
3. Select an option from the **Type of Service** drop-down.
4. Select an option from the **Level of Care** drop-down.
5. Select an option from the **Type of Care** drop-down.
6. Enter a date in the **Admit Date** field.
7. Enter a time in the **Admit Time** field.
8. Select either **Yes** or **No** in the **Has the member already been admitted to the facility?** field.

Note:

- This question displays only if the level of service is Inpatient/HLOC/Specialty.
- This question is required if the level of service is Inpatient/HLOC/Specialty and any combination of type of service, level of care, and type of care is selected.

9. Attach any applicable documents and click **Next**.



Requested Services Header

All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

*Requested Start Date (MMDDYYYY) *Level of Service

Provider
Tax ID Provider ID Provider Last Name Vendor ID Provider Alternate ID **588531100**

Member
Member ID Last Name First Name Date of Birth (MMDDYYYY)

Attach a Document

Complete the form below to attach a document with this Request
The following fields are only required if you are uploading a document

*Document Type: Does this Document contain clinical information about the Member? Yes ☐ No ☐

*Document Description: Click to attach a document Click to delete an attached document

Attached Document:

Figure 58: Requested Services Header



A page containing three tabs displays.

Only the fields with asterisks () are required.*

Level of Care/Diagnosis

The Level of Care/Diagnosis page is completed first.

Information Requested by Clinician for Inclusion in this Request

This section contains information entered on the Focus of Next Clinical Review page in Service/CareConnect. Clinicians use that screen to enter information they would like to see from the provider on the next request. The information entered by the clinician is displayed in ProviderConnect so that the provider can make sure to include it in the request that he/she is submitting. (The information is read-only.) Note that:

- If the most recent previous review is blank, neither the field nor the field label displays as no information was entered for the review.
- If multiple concurrent reviews occur, only the most recently added Focus of Next Clinical Review narrative displays.

Level of Care

This section contains level of care and type of service as well as contact and primary care coordination information fields.

1. Verify the level of care and type of service.
2. Select the **Treatment Includes ECT** checkbox if applicable.
3. Select the **Treatment Includes Psych Testing** checkbox if applicable.
4. Enter aftercare follow-up contact information for the member.
 - Phone #
 - E-mail
 - Validate E-mail

Note: Phone #, E-mail, or N/A is required. If N/A, the provider must explain why aftercare follow-up information is not available.

5. Enter primary care coordination information.

- PCP Contacted Status **(REQUIRED)**

Note: If the PCP contacted status is either **Care Plan Sent to PCP** or **PCP Contacted**, the PCP contact name and date are required.

- PCP Contacted Name
 - Date Contacted
6. Enter at least one contact name and phone number.

Metabolic Assessment Tool

Current Weight lbs Height ft in Waist Circumference in inches in BMI

BMI Categories: Underweight < 18.5 Normal weight = 18.5-24.9 Overweight = 25-29.9 Obese = BMI of 30 or greater.

Results of BMI indicate that the member may be Recommendation

Additional information on Metabolic Syndrome and assessment tools are available at <http://www.valueoptions.com/providers/Protocols.htm>. A direct link to the page is available on the Provider Home Page of ProviderConnect under Clinical Support Tools or you may click on the above link to open directly in a separate browser window.

Results of Metabolic Syndrome Assessment

☐ BMI not assessed

Please provide additional information on reason for not obtaining BMI or if recommendation is to follow-up, details around the follow-up when available.

(0 of 2000)

Figure 60: Metabolic Assessment Tool

Clinical Presentation/Medication/Treatment

The Clinical Presentation/Medication/Treatment page displays next.

Information Requested by Clinician for Inclusion in this Request

This section contains information entered on the Focus of Next Clinical Review page in Service/CareConnect. Clinicians use that screen to enter information they would like to see from the provider on the next request. The information entered by the clinician is displayed in ProviderConnect so that the provider can make sure to include it in the request that he/she is submitting. (The information is read-only.) Note that:

- If the most recent previous review is blank, neither the field nor the field label display as no information was entered for the review.
- If multiple concurrent reviews occur, only the most recently added Focus of Next Clinical Review narrative displays.

Symptomatology

This section contains the following fields along with these instructions: *“Please explain the reason for current admission (describe symptoms) and include the precipitant (what stressor or situation led to this decompensation). If this is a concurrent request, please list both the progress that has been made to date and what symptoms still remain.”*

- Narrative Entry
- Member’s Risk to Self
 - Danger to Self Symptom Complex*

** Required if member’s risk to self is a 2 or 3.*

- Member’s Risk to Others
 - Danger to Others Symptom Complex*

** Required if member’s risk to others is a 2 or 3.*

- Substance Use
- Urine drug screen?*

**Urine drug screen is required for the RFS workflow if member’s substance use is a 2 or 3 OR Type of Service = Substance Use OR Primary Behavioral Diagnostic Category for the incoming request is one of the following:*

- Alcohol-Related Disorders
- Cannabis-Related Disorders
- Combined Other Substance Disorders
- Hallucinogen-Related Disorders
- Inhalant-Related Disorders
- Opioid-Related Disorders
- Sedative-, Hypnotic-, or Anxiolytic-Related Disorders
- Stimulant-Related Disorders

- Outcome of UDS
- Date of Urine Drug Screen
- Positive for*

**At least one substance or “Other” must be selected if the outcome of the urine drug screen is positive.*

- Blood Alcohol*

** Blood Alcohol or N/A is required for the RFS workflow if member’s substance use is a 2 or 3 OR Type of Service = Substance Use OR Primary Behavioral Diagnostic Category for the incoming request is one of the following:*

- o Alcohol-Related Disorders
- o Cannabis-Related Disorders
- o Combined Other Substance Disorders
- o Hallucinogen-Related Disorders
- o Inhalant-Related Disorders
- o Opioid-Related Disorders
- o Sedative-, Hypnotic-, or Anxiolytic-Related Disorders
- o Stimulant-Related Disorders

- Blood Alcohol N/A*

Checkbox is required if **Blood Alcohol is left blank.*

Primary Issues/Symptoms Addressed in Treatment

This section comprises a number of symptom complexes. Note that:

- For each symptom complex that is “triggered” as being required when completing a request for service, the applicable sections are automatically expanded upon accessing the Clinical Presentation/Medication/Treatment tab.
- Sections can also be manually expanded/collapsed.
- If a particular symptom complex is expanded, the associated Narrative Entry textbox is also expanded by default. If a particular system complex is required, then the associated Narrative Entry is also required.

The following directive displays just below the section title: “*Symptom complexes are utilized for gathering clinical information specific to the primary behavioral diagnosis and/or risk. At times more than one complex may be identified for completion. Providing all the requested information in the identified complex(es) will assist in completing the authorization process and determining medical necessity. If this is a concurrent request, please update the identified complexes with any new information for each complex based on the individual’s current symptomatology.*”

Recovery and Resiliency

This section contains a Narrative Entry textbox along with the following instructions: “*Please outline the recovery and resiliency environment to support this individual’s long-term recovery plan. Please include personal strengths, support systems available to support the recovery and details around living environment, as well as outline any identified needs or supports that need to be put in place to assist in the successful recovery.*”

Medications

This section enables the provider to view and modify information regarding current and historical medications for the member. He/she can also add new medications as needed.

Add a Medication

Upon clicking **Add Medication**, the system displays data entry fields for adding a new medication. (If there are no medications on file for the member, the system displays a blank set of data entry fields upon accessing this page.)

The system also displays a separate medication-related Narrative Entry textbox along with the following instructions: *“For this medication, please enter any details concerning dosage, side effects, adherence, effectiveness, prescribing provider and any specific target symptoms.”*

Clicking the **Add Medication** button again adds a new medication record. Medications are saved upon submitting the request for services.

Note

Up to 10 medications can be added per request for services.

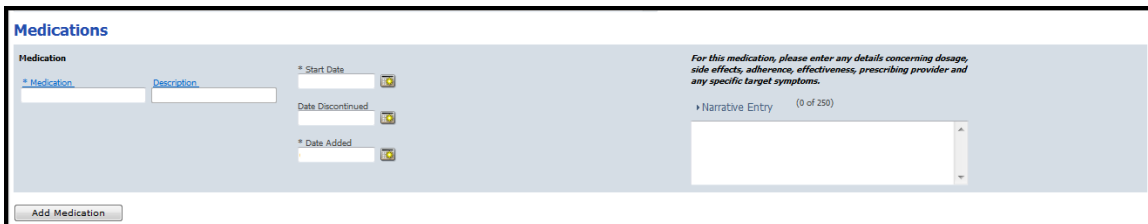


Figure 61: Add a Medication

Best Practices Endorsement

This section utilizes the Primary Behavioral Diagnostic Category entered on the Diagnosis page for the incoming request and dynamically updates the [Best Practice Guidelines Related to Primary Behavioral Diagnosis](#) hyperlink with the PDF document associated to that particular diagnostic category. (If there is no match, then a generic PDF document displays.)

Respond either **Yes** or **No** to the following statement: *“I endorse that I follow Best Practice Guidelines for the Primary Behavioral Diagnosis.”*

If the answer is **No**, you must give a reason why you do not endorse best practice guidelines related to the primary behavioral diagnosis.

Note

The best practices endorsement statement is required.

Additional Information on Selected Conditions

This section utilizes the Primary Behavioral and Medical Diagnostic Categories entered on the Diagnosis page for the incoming request and automatically displays hyperlinked descriptions for those categories. (The system can display up to five hyperlinked descriptions per category. Upon selecting a particular link, the system opens the applicable Achieve Solutions® web page.)



If no active hyperlinks exist for a particular diagnostic category, the following message appears: ***"No links to display."***

Discharge Information

This section contains the following instructions: *"Discharge planning considerations should include obtaining releases to speak to and coordinate care with the providers that individual will be transitioning to as well as confirming that appointments are timely scheduled. Discharge planning should be included as a component of the treatment throughout the entire stay. (HEDIS measures require follow-up within 7 days to discharge. Requirements may be sooner based on individual circumstances.)"*

Complete the following information.

1. Planned Discharge Level of Care
2. Other Planned Discharge Level of Care (if applicable)
3. Planned Discharge Residence
4. Other Planned Discharge Residence (if applicable)
5. Expected Discharge Date



Planned Discharge Level of Care and Planned Discharge Residence are required for all requests for services. Expected Discharge Date is required for concurrent requests for services.

Discharge Information

Discharge planning considerations should include obtaining releases to speak to and coordinate care with the providers that individual will be transitioning to as well as confirming that appointments are timely scheduled. Discharge Planning should be included as a component of the treatment throughout the entire stay. (HEDIS measures require follow-up within 7 days to discharge. Requirements may be sooner based on individual circumstances.)

* Planned Discharge Level of Care

OTHER

Other Planned Discharge Level of Care

* Planned Discharge Residence

OTHER

Other Planned Discharge Residence

Expected Discharge Date (MMDDYYYY)

Figure 62: Discharge Information

Additional Information

The Additional Information page contains parent-specific custom fields from the ITR form and displays for concurrent requests for services *only*. If there is no parent-specific information for a particular parent, the following message displays: “No additional information is required.”

Medication Management Level of Service

If the **Medication Management** level of service is selected, the number of steps in the process is reduced and only three tabs are displayed.

1. Select **Medication Management** from the **Level of Service** drop-down.
2. Click **Next**.

The Diagnosis page displays next.

3. Enter the **Contact Name** and **Phone Number** of the person to be contacted if additional information is needed.
4. Enter the member's diagnosis information. (Refer to the [Diagnosis](#) section under [Outpatient ORF2](#) authorization requests.)

The Requested Services page displays next.

5. Select an option from the **Place of Service** drop-down.
6. Click **Add/Modify Service Classes** and select the appropriate service class from the list. (Up to 20 service classes can be selected.)

The number of visits/units auto-populate. If more than one service is requested:

7. Enter information on additional lines.
8. Enter the number of visits in the **Visits/Units** field.
9. Go back and modify the **Visits/Units** field in the previous line so that the **Total Visits/Units** amount does not exceed 20.
10. Click **Submit**.

The Determination Status page displays next.

Decrease Approved Visits

VSP and in-network providers can choose to decrease the number of visits approved for the request for services (RFS). When units are offered for potential auto-approval, accepting that number of units or requesting fewer units may result in automatic authorization. Requests for a greater number of units will need to pend for further review.

To decrease the number of approved visits:

1. Click **Reject**.

The following pop-up window displays.

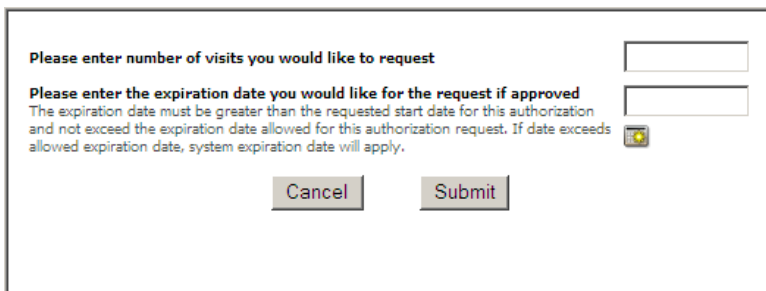


Figure 63: Number of Visits & Expiration Date Pop-up

2. Enter the new number in the **Please enter number of visits you would like to request** field.
3. Optionally enter a date in the **Please enter the expiration date you would like for the request if approved** field.

Note: *The expiration date must be greater than the requested start date for this authorization and not exceed the expiration date allowed for this authorization request. If the date exceeds the allowed expiration date, the system expiration date applies.*

4. Click **Submit**.

The Requested Services page displays.

5. Complete the fields on the Requested Services page if necessary.
6. Verify the **Visits/Units** amount.
7. Click **Submit**.

The Results page displays reflecting the modified amount of visits/units.

11

Enter an ABA Authorization Request

The following Applied Behavioral Analysis (ABA) outpatient workflows/pages are available for providers to evaluate and determine the appropriate course of treatment for members with Autism Spectrum Disorder or other Intellectual Developmental Disabilities.

- [ABA Assessment](#)
- [ABA Services](#)

ABA Assessment Workflow

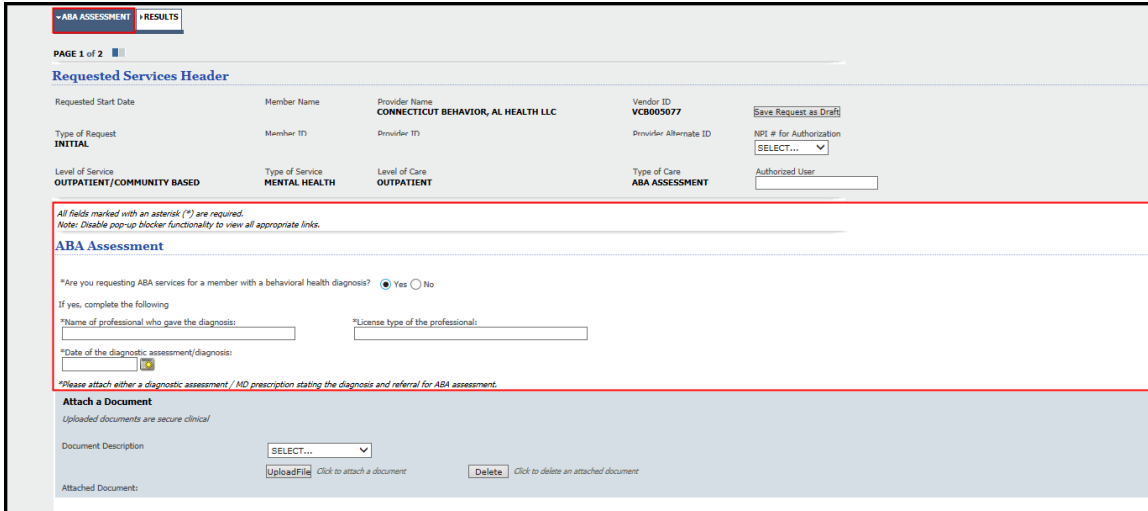
The ABA Assessment workflow is initiated upon a provider completing the requested services header information as follows.

- Level of Service – Outpatient
- Type of Service – Mental Health
- Level of Care – Outpatient
- Type of Care – ABA Assessment

The following initial Yes/No question displays upon clicking **Next**: “Are you requesting ABA services for a member with a behavioral health diagnosis?”

If the answer to this question is **Yes**, the following fields must be completed.

- Name of professional who gave the diagnosis
- License type of the professional
- Date of the diagnostic assessment/diagnosis



ABA ASSESSMENT **RESULTS**

PAGE 1 of 2

Requested Services Header

Requested Start Date: Member Name: Provider Name: CONNECTICUT BEHAVIOR, AL HEALTH LLC Vendor ID: VCB005077 Save Request as Draft

Type of Request: INITIAL Member ITN: Provider ITN: Provider Alternate ID: NPI # for Authorization: SELECT...
 Level of Service: OUTPATIENT/COMMUNITY BASED Type of Service: MENTAL HEALTH Level of Care: OUTPATIENT Type of Care: ABA ASSESSMENT Authorized User:


All fields marked with an asterisk (*) are required.
 Note: Disable pop-up blocker functionality to view all appropriate links.

ABA Assessment

*Are you requesting ABA services for a member with a behavioral health diagnosis? ☒ Yes ☐ No

If yes, complete the following

*Name of professional who gave the diagnosis: *License type of the professional:

*Date of the diagnostic assessment/diagnosis: 

*Please attach either a diagnostic assessment / MD prescription stating the diagnosis and referral for ABA assessment.

Attach a Document

Uploaded documents are secure clinical

Document Description: SELECT...
 UploadFile Click to attach a document Delete Click to delete an attached document

Attached Document:

Figure 64: ABA Assessment

Attach a Document

The provider is required to upload supporting documentation for both initial and concurrent requests.

The provider then completes the standard Diagnosis page. (Refer to the [Diagnosis](#) section of the [Enter an Authorization Request \(RFS\)](#) chapter for detailed information.)

ABA Services Workflow

The ABA Services workflow is initiated upon a provider completing the requested services header information as follows.

- Level of Service – Outpatient
- Type of Service – Mental Health
- Level of Care – Outpatient
- Type of Care – ABA Services

The following initial Yes/No question displays upon clicking **Next**: “Are you requesting ABA services for a member with a behavioral health diagnosis?”

If the answer to this question is **Yes**, the provider must “complete the following information and documentation” and “if previously submitted, please indicate.” (Select the **Already submitted** checkbox if documentation has already been submitted.)

- Name of professional who gave the diagnosis
- License type of the professional
- Date of the diagnostic assessment/diagnosis

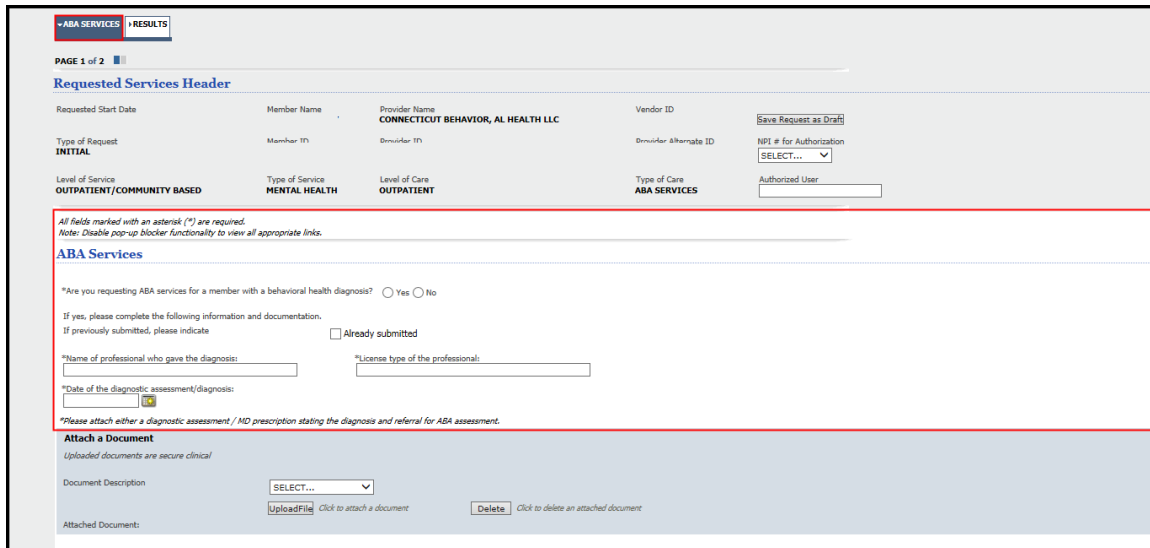


Figure 65: ABA Services

Attach a Document

- Supporting documentation is *required* if the answer to the “Are you requesting ABA services for a member with a behavioral health diagnosis?” question is **Yes**.
- Supporting documentation is *not required* if the answer to the “Are you requesting ABA services for a member with a behavioral health diagnosis?” question is **No**.
- Supporting documentation is *not required* if the provider has indicated that documentation has already been submitted.

The provider then completes the standard Diagnosis page. (Refer to the [Diagnosis](#) section of the [Enter an Authorization Request \(RFS\)](#) chapter for detailed information.)

The following required fields display below the Diagnosis page.

- Is member receiving other professional services?
 - If the answer to this question is **Yes**, the provider must select one or more of the services listed or select **Other**.
- Is member taking any medication?
 - If the answer to this question is **Yes**, the provider must enter the applicable information.

The provider then completes the *Current Impairments* and *Current Skills Impairments* sections.



- Ratings for *Current Impairments* are: 0 (none), 1 (mild/mildly incapacitating), 2 (moderate/moderately incapacitating), 3 (severe/severely incapacitating), or ANC (assessment not completed)
- Ratings for *Current Skills Impairments* are: 0 (age appropriate), 1 (1 to 2 years below), 2 (3 to 4 years below), 3 (5 or more years below), or ANC (assessment not completed)

The following free text field displays next: “Please outline areas of progress since last review, as well as areas that need to be focus of future treatment. If there has been a lack of progress, please indicate the actions to adjust or change treatment plan to address lack of progress. Include a summary of the Transition/Discharge Plan and any additional resources or referrals that are needed for the member and their family.”

This field is required for concurrent requests for services only.

The following instructions display next: “Please refer to <http://www.beaconhealthoptions.com/providers/Forms/Clinical/ABA-Provider-Progress-Report-Guidelines.pdf> to download Beacon Health Options ABA report guidelines.”

“Providing the following components in the report will help determine medical necessity.”

- Member’s basic bio-psychosocial
- Member’s skill impairments
- List of data source/tools used
- Intervention plan (including baseline data)
- Transition & discharge plan

- Member's strengths/capabilities
- Crisis Plan
- Parent training
- Coordination of care
- Description of supervision

The provider is required to upload documentation for concurrent ABA services only.

Concurrent ABA Services

The following fields display only for concurrent ABA requests for services.

- Follow-up considerations for concurrent review.
- Number of member behavior goals targeted during current authorization period.
- How many member behavior goals were met?
- Number of new member behavior goals added for next authorization period.
- Re-assessment tools used. Check all that apply.

Note: The provider must select one or more of the re-assessment tools listed or select **Other**.

- During recent authorization period were there any gaps in treatment?



12

ABA Tracking Measures

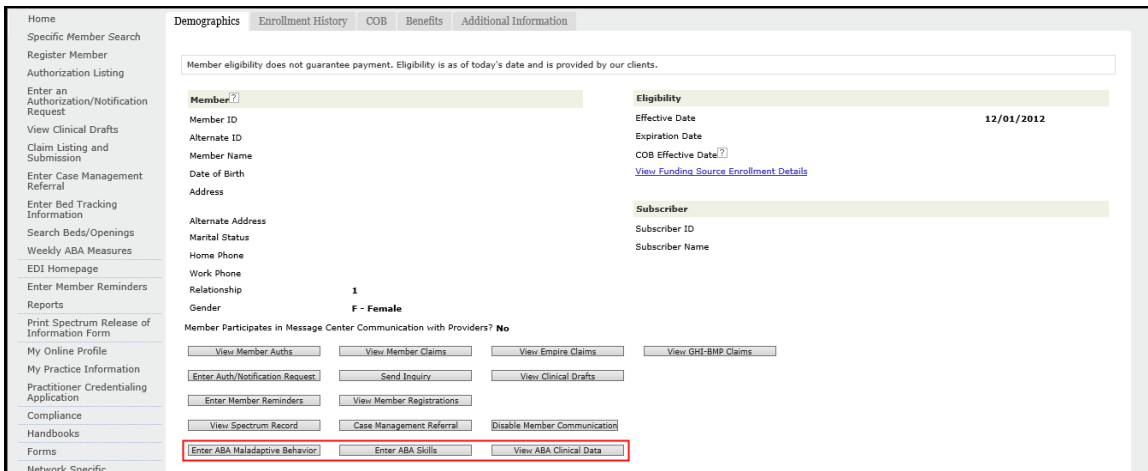
Applied Behavioral Analysis (ABA) Maladaptive Behavior and Skills Data Tracking functionality is available in ProviderConnect for providers who have the appropriate clinical function(s) assigned to their user security role.

To access this feature:

1. Click on [Weekly ABA Measures](#). (The member search page displays.)
2. Search for the appropriate member. (The Demographics page displays.)

From the Demographics page the user can:

- [Enter weekly maladaptive behavior updates for the current member](#),
- [Enter weekly skills updates for the current member](#), or
- [View ABA clinical data](#).



The screenshot shows the 'Demographics' tab of a member's profile in ProviderConnect. The page includes a left sidebar with navigation links, a top navigation bar with tabs (Home, Demographics, Enrollment History, COB, Benefits, Additional Information), and a main content area. The main content area displays member information such as Member ID, Alternate ID, Member Name, Date of Birth, Address, Alternate Address, Marital Status, Home Phone, Work Phone, Relationship, and Gender. It also shows eligibility information (Effective Date, Expiration Date, COB Effective Date) and subscriber information (Subscriber ID, Subscriber Name). At the bottom of the main content area, there are several buttons for data entry and viewing, including 'Enter ABA Maladaptive Behavior', 'Enter ABA Skills', and 'View ABA Clinical Data', which are highlighted with a red box.

Figure 66: ABA Maladaptive Behavior & ABA Skills Data Tracking Buttons

Enter ABA Maladaptive Behavior

Clicking the **Enter ABA Maladaptive Behavior** button redirects the user to the ABA Maladaptive Behavior page for him/her to enter weekly maladaptive behavior updates for the member.

 Note

*This button also displays if accessing the Demographics page via the **Specific Member Search** or **Find a Specific Member** option.*

Read-only Information

The following read-only fields display in the page header.

- Record #
- Member Name
- Member ID
- Date of Birth
- Age

The user is prompted to select the week for which he/she will be entering/editing data.

 Note

*The **No Maladaptive Behavior Data to report this week** checkbox should be selected if there is no data to report for the current week. (This checkbox is required if no data is entered.)*

The user can also search for an existing maladaptive behavior data record by selecting the appropriate week from the calendar.

Upon making a selection, the following read-only fields display.

- **Added By** – Displays the ID of the person who submitted the maladaptive behavior data.
- **Date Added** – Displays the date the maladaptive behavior data was submitted.
- **Changed By** – Displays the ID of the person who last edited the maladaptive behavior data.
- **Date Changed** – Displays the date the maladaptive behavior data was last edited.

Data Entry Fields

The following fields display in tabular format.

- **Baseline** – Contains checkboxes associated with each of the behavior types. Baseline selections (checkmarks) apply only to the week those particular behavior types are first evaluated. They do not carry over to subsequent weeks. (That is, the checkboxes are cleared.)
- **Behavior Type** – Contains a read-only list of behavior types.
- **Behavior Name** – Allows the user to select a behavior associated with a particular behavior type. If **Other**, a 25-character textbox displays for the user to enter the other behavior. (Behavior names are based on behavior type.)
- **Measurement Type** – Allows the user to select a measurement type for the behavior.
- **Measurement Units** – Allows the user to select a measurement unit for the measurement type. (Default measurement units are based on measurement type.)
- **Interval Units** – Allows the user to enter the interval units. (Only numeric values are permitted and can include decimals.)
- **Data Value** – Allows the user to enter a data value. (Only numeric values are permitted and can include decimals.)

Submit ABA Maladaptive Behavior Data

Upon clicking **Submit**, the system validates the data and displays the determination status. (See: [Weekly ABA Measures Confirmation](#))

Enter ABA Skills

Clicking the **Enter ABA Skills** button redirects the user to the ABA Skills page for him/her to enter weekly skills updates for the member.

 Note

*This button also displays if accessing the Demographics page via the **Specific Member Search** or **Find a Specific Member** option.*

Read-only Information

The following read-only fields display in the page header.

- Record #
- Member Name
- Member ID
- Date of Birth
- Age

The user is prompted to select the week for which he/she will be entering/editing data.

 Note

*The **No Skills Data to report this week** checkbox should be selected if there is no data to report for the current week. (This checkbox is required if no data is entered.)*

The user can also search for an existing skills record by selecting the appropriate week from the calendar.

Upon making a selection, the following read-only fields display.

- **Added By** – Displays the ID of the person who submitted the skills data.
- **Date Added** – Displays the date the skills data was submitted.
- **Changed By** – Displays the ID of the person who last edited the skills data.
- **Date Changed** – Displays the date the skills data was last edited.

Data Entry Fields

The following sections display. Each section contains a number of textboxes in which the user can enter values ranging from 1 – 20.

- Readiness Skills
 - Attending
 - Fine Motor
 - Gross Motor
 - Motor Imitation
 - Routine/Schedule
 - Visual Performance
- Language/Communication
 - Intraverbals
 - Label/Tact
 - Receptive Language
 - Request/Mands
 - Social Interactions
 - Syntax and Grammar
 - Vocal Imitation
- Daily Living/Self-Help
 - Chores
 - Dressing
 - Eating
 - Grooming
 - Play and Leisure
 - Toileting
 - Vocational
- Social Skills
 - Group Instruction
 - Pragmatic Language
 - Social Interaction
- Academics
 - Math
 - Reading
 - Spelling
 - Writing
- Generalized Responding
 - Academics
 - Cognitive Functioning
 - Daily Living/Self Help
 - Language/Communications
 - Readiness Skills
 - Safety
 - Social Skills

Submit ABA Skills Data

Upon clicking **Submit**, the system validates the data and displays the determination status.
(See: [Weekly ABA Measures Confirmation](#))

View ABA Clinical Data

Upon clicking the **View ABA Clinical Data** button, the system authenticates the submitter ID and then passes the member number parameters to IntelligenceConnect. Upon success of the user authentication and the above parameters being passed, the user is redirected to the IntelligenceConnect application where he/she can view the ABA Maladaptive Behaviors and ABA Skills Graphical Reports.



*This button also displays if accessing the Demographics page via the **Specific Member Search** or **Find a Specific Member** option.*

Weekly ABA Measures Confirmation

Upon clicking **Submit** on either the ABA Maladaptive Behavior or ABA Skills page, the system validates the data and redirects the user to the appropriate Determination Status page. The following information displays on this page.

- Member Name
- Member ID
- Member DOB
- Record #
- Type of Request
- From – To (Dates)
- Submission Date
- Provider Name & Address
- Provider ID

Clicking the **Enter Maladaptive Behavior Data** button redirects the user to the [ABA Maladaptive Behavior](#) page.

Clicking the **Enter ABA Skills** button redirects the user to the [ABA Skills](#) page.

Users also have the ability to:

- Print the maladaptive behaviors/skills results,
- Print the maladaptive behaviors/skills request,
- Download the maladaptive behaviors/skills request, or
- Return to the ProviderConnect home page.

13

Review an Authorization – EAP CAF

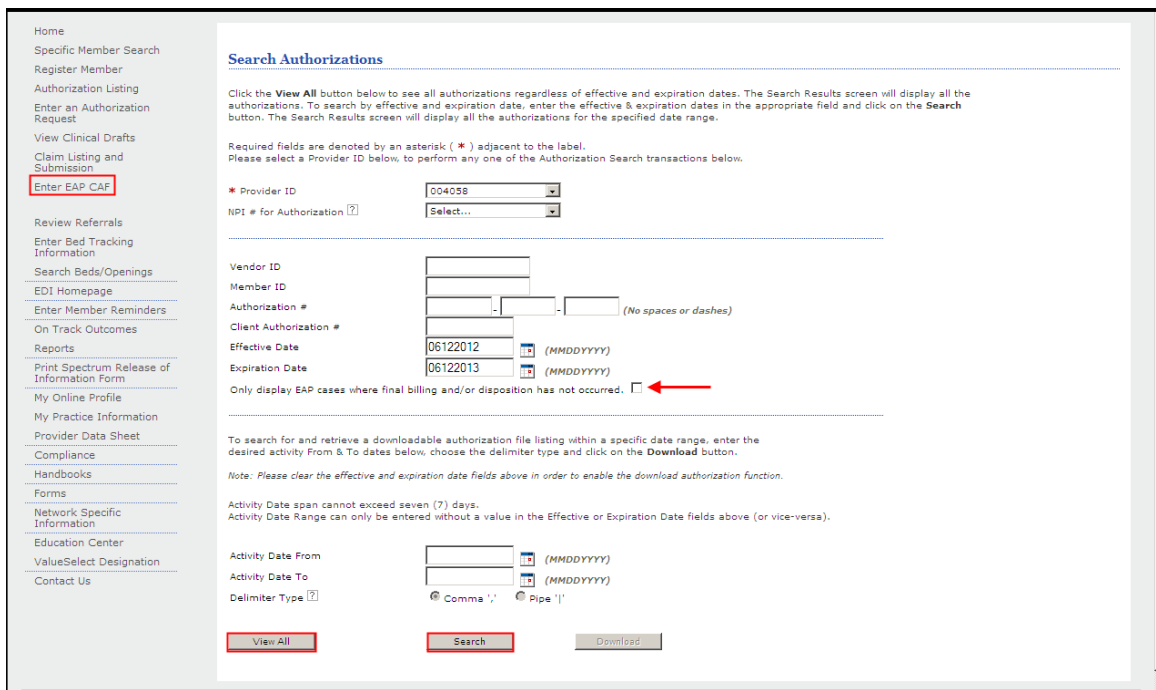
The *Review an Authorization Request* function enables providers to electronically perform an authorization search by provider ID. Network providers authorized to perform EAP Services can submit their one-page version of the CAF-1 / Billing Form from within this section.

Upon clicking [Review an Authorization](#), the Search Authorizations page displays.

The provider ID auto-populates along with the current date.

Note

1. Enter the member ID, authorization #, and/or authorization dates on the Search Authorizations page.
2. Select the **Only display EAP cases where final billing and/or disposition has not occurred** checkbox if you want only those EAP authorizations that are tied to open EAP cases and that meet the stated conditions to be returned in the search results.
3. Click either **Search** or **View All**.



Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
View Clinical Drafts
Claim Listing and Submission
Enter EAP CAF
Review Referrals
Enter Bed Tracking Information
Search Beds/Opening
EDI Homepage
Enter Member Reminders
On Track Outcomes
Reports
Print Spectrum Release of Information Form
My Online Profile
My Practice Information
Provider Data Sheet
Compliance
Handbooks
Forms
Network Specific Information
Education Center
ValueSelect Designation
Contact Us

Search Authorizations

Click the **View All** button below to see all authorizations regardless of effective and expiration dates. The Search Results screen will display all the authorizations. To search by effective and expiration date, enter the effective & expiration dates in the appropriate field and click on the **Search** button. The Search Results screen will display all the authorizations for the specified date range.

Required fields are denoted by an asterisk (*) adjacent to the label.
Please select a Provider ID below, to perform any one of the Authorization Search transactions below.

* Provider ID: 004058
NPI # for Authorization: Select...

Vendor ID:
Member ID:
Authorization #:
Client Authorization #:
Effective Date: 06/22/2012 (MMDDYYYY)
Expiration Date: 06/22/2013 (MMDDYYYY)

Only display EAP cases where final billing and/or disposition has not occurred. ☐

To search for and retrieve a downloadable authorization file listing within a specific date range, enter the desired activity From & To dates below, choose the delimiter type and click on the **Download** button.

Note: Please clear the effective and expiration date fields above in order to enable the download authorization function.

Activity Date span cannot exceed seven (7) days.
Activity Date Range can only be entered without a value in the Effective or Expiration Date fields above (or vice-versa).

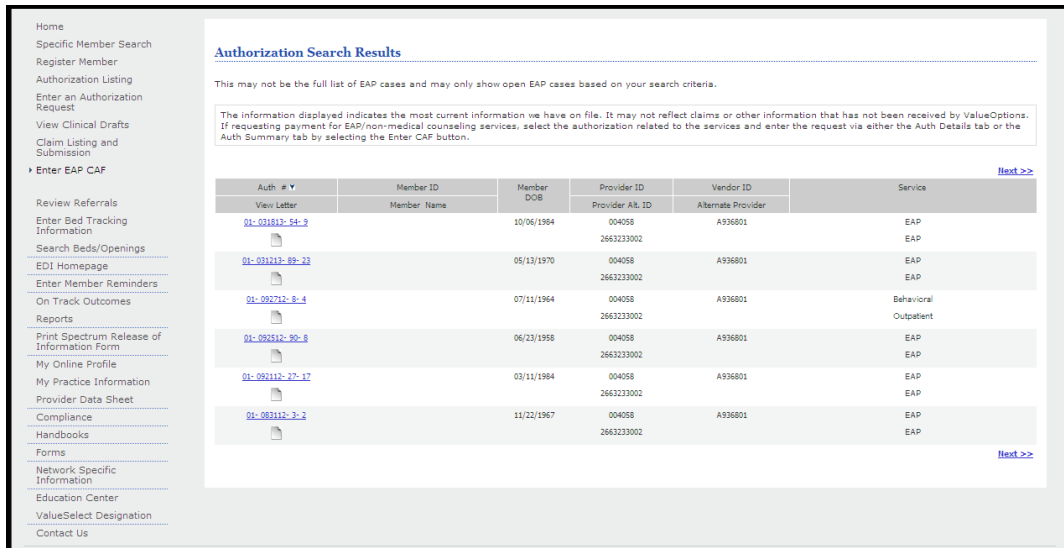
Activity Date From:
Activity Date To:
Delimiter Type: @ Comma ',' @ Pipe '|'
View All Search Download

Figure 67: Search Authorizations

The Authorization Search Results page displays.



If the provider's security role contains the EAP CAF function, [Enter EAP CAF](#) links appear on the ProviderConnect home page. Clicking either of these links redirects the provider to the Authorization Search Results page. (Be aware that only the EAP authorizations that are tied to open EAP cases are listed.)



Auth #	Member ID	Member Name	Member DOB	Provider ID	Provider Alt. ID	Vendor ID	Alternate Provider	Service
01-031813-54-9			10/06/1984	004058		A936801		EAP
				2663233002				EAP
01-031112-89-23			05/13/1970	004058		A936801		EAP
				2663233002				EAP
01-092712-8-4			07/11/1964	004058		A936801		Behavioral Outpatient
				2663233002				
01-092512-90-8			06/23/1958	004058		A936801		EAP
				2663233002				EAP
01-091112-17-17			03/11/1984	004058		A936801		EAP
				2663233002				EAP
01-083112-3-2			11/22/1967	004058		A936801		EAP
				2663233002				EAP

Figure 68: Authorization Search Results

- Click on the [Authorization #](#) adjacent to the appropriate service.

Note: Member IDs also display as links, but were deleted to protect members' privacy.

The Auth Summary page displays.

- Click the **Auth Details** tab to view the authorization details.

The Auth Details page displays.

- Click the **Enter EAP CAF** button on either the Auth Summary tab or Auth Details tab to start the CAF (Case Activity Form) entry process.

EAP Case Activity and Billing Form

CAF Date
06/14/2013

Client Company/Organization
AT&T IHC.

*Billing Type
SELECT...

Participant Relationship to Employee

PARTICIPANT INFORMATION

Member ID

Member Name

Member DOB
10/06/1984

Gender
Male

*Statement of Understanding Signed? ☐ Yes ☐ No

*Participant Relationship to Employee **SELF**

EAP Clinician

Provider Name
SEHEL, HARY

Provider ID
004058

Provider Alternate ID
2663233002

Tax ID
070344922

*NPI Number
SELECT...

Assessed Problem

*One Assessed Problem Indicator is required

☐ Adult/Elder Care ☐ Drugs ☐ Hyperactivity/Learning ☐ Medical
☒ Alcohol ☐ Eating Disorder ☐ Impulse Control ☐ Mixed Alcohol/Drug Abuse
☐ Anxiety ☐ Family Problems ☐ Job/Occupational ☐ Thought Disorder
☐ Child Care ☐ Financial Problems ☐ Legal ☐ Situational/Adjustment
☐ Depression ☐ Grief/Loss ☐ Marital / Relationship

Risk and Functional Assessment

Indicate Impairment Level at Case Opening and Case Closing

Key: 0 = No Evidence of Impairment 1 = Mild 2 = Moderate 3 = Severe N/A = Not Assessed

CASE OPENING

*Member's Risk to Self
--COMPLETED--

*Member's Risk to Others
--COMPLETED--

*Mood Disturbances (Depression or Mania)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Anxiety
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Thinking/ Cognition/ Memory/ Concentration Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Impulsive/ Reckless/ Aggressive Behavior
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Activities of Daily Living Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Medical/ Physical Conditions
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Substance Abuse/ Dependence
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Job/ School Performance Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Social Functioning/ Relationships/ Marital/ Family Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

CASE CLOSING

*Member's Risk to Self
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Member's Risk to Others
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Mood Disturbances (Depression or Mania)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Anxiety
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Thinking/ Cognition/ Memory/ Concentration Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Impulsive/ Reckless/ Aggressive Behavior
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Activities of Daily Living Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Medical/ Physical Conditions
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Substance Abuse/ Dependence
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Job/ School Performance Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

*Social Functioning/ Relationships/ Marital/ Family Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

Case Closing

Is this a case closing with no dates of service to submit claim for? ☐ Yes ☐ No

Problem Status at Case Closing
SELECT...

Case Disposition
SELECT...

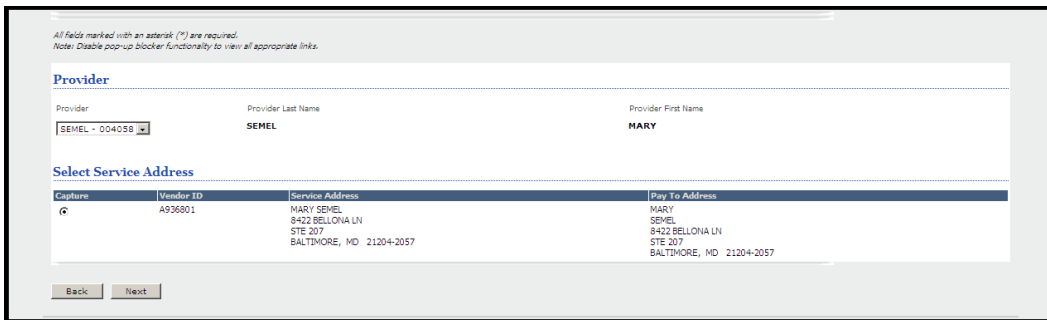
Primary Referral Type

☐ No Referral Beyond EAP
☐ Medical Treatment
☐ Community Resource
☐ Substance Abuse Treatment
☐ Psychiatric Treatment

Figure 69: Case Activity Form (CAF)

7. Enter all the EAP Case Activity and Billing Information and click **Next**. Providers have the ability to submit an EAP CAF without executing a claim submission by answering **Yes** to the **Is this a case closing with no dates of service to submit claim for?** question. The claims section is bypassed, leaving the date of service blank.

The Select Service Address page displays next.



All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

Provider

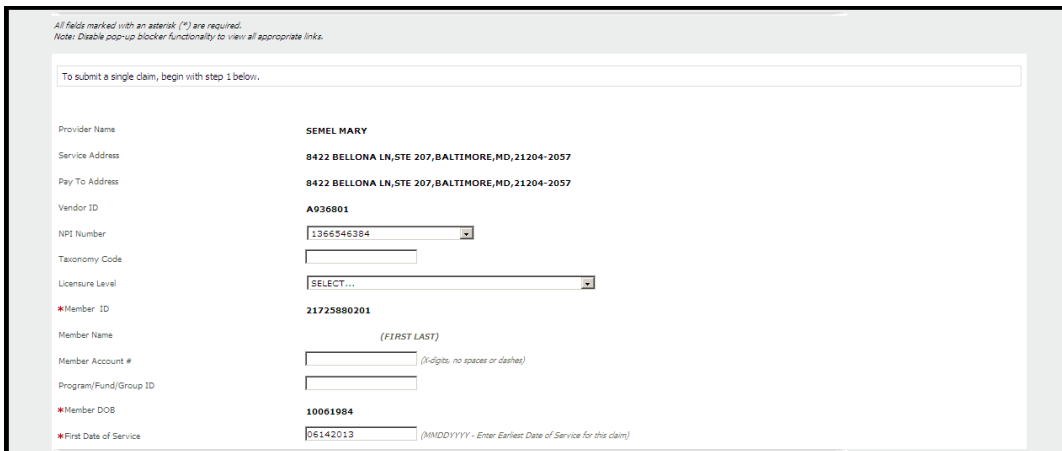
Provider: Provider Last Name: SEMED Provider First Name: MARY

Select Service Address

Capture	Vendor ID	Service Address	Pay To Address
<input checked="" type="radio"/>	A936801	MARY SEMED 8422 BELLONA LN STE 207 BALTIMORE, MD 21204-2057	MARY SEMED 8422 BELLONA LN STE 207 BALTIMORE, MD 21204-2057

Figure 70: Select a Service Address

8. Enter the necessary information and click **Next**.
9. The Step 1 of 2 page for submitting a claim displays. Enter the applicable information and click **Next**.



All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

To submit a single claim, begin with step 1 below.

Provider Name: SEMED MARY

Service Address: 8422 BELLONA LN, STE 207, BALTIMORE, MD, 21204-2057

Pay To Address: 8422 BELLONA LN, STE 207, BALTIMORE, MD, 21204-2057

Vendor ID: A936801

NPI Number:

Taxonomy Code:

Licensure Level:

Member ID: 21725880201

Member Name: (FIRST LAST)

Member Account #: (8-digits, no spaces or dashes)

Program/Fund/Group ID:

Member DOB: 10061984

First Date of Service: 06142013 (MMDDYYYY - Enter Earliest Date of Service for this claim)

Figure 71: Step 1 of 2

10. The Step 2 of 2 page for submitting a claim displays. Enter the applicable information and click **Submit**.

All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

Member ID	Member Name	Birth Date	NP1 Number	Service Address	Pay To Address
10/06/1984			1366546384	8422 BELLONA LN,STE 207,BALTIMORE,MD,21204-2057	8422 BELLONA LN,STE 207,BALTIMORE,MD,21204-2057

To enter detail service lines for the claim, please follow these steps:
1. Enter your first (or only) service line entry.
2. Click the "Add Service Line" button to add that information into the claim.
3. Repeat steps 1-2 as needed, up to a maximum of 10 service lines.

Service Line Entry

Service Date: (MM/DD/YYYY) Units: (2-digits)

Add Service Line This will add this service line information to the claim

To remove a service line, select the "Click to Remove" button for the line needed to be removed, then click the "Remove" button below

Remove Submit Previous

This will remove the service line selected above This will submit the entire claim (including all service lines added) This will return to the preceding data entry page

Figure 72: Step 2 of 2

The Case Activity & Billing process is complete.

The following **Submission Printing Options** display at the bottom of the results page.



- Print Submission Result
- Print Submission
- Download Submission

Submission Status : ***** CASE ACTIVITY & BILLING FORM SUBMITTED SUCCESSFULLY *****

Your Case Activity & Billing Form has been successfully submitted.

Member Name	Member ID	Member DOB	Subscriber Name	Subscriber ID

Authorization #	Client Authorization #	Claim #
01-031813-54-9	N/A	01- 061413- 4069- 1

Date of Admission/ Start of Services	Requested From	Submission Date
06/14/2013	06/14/2013	06/14/2013

Level of Service
EAP

Provider Name & Address	Provider ID	Provider Alternate ID	NP1 Number	Vendor ID
MARY SEMEL 8422 BELLONA LN STE 207 TOWSON MD 21204	004058	2663233002	1366546384	A936801

Claim Details

Line #	Service Date	Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	To-Pay	Status	Dollar Amount (\$)					Fund
									Allowed	Deductible	Pre-Paid	COIN	CoPay	
1	06/14/2013	06/14/2013	AEA	60	60.00	799.9	60.00	A	60.00	0.00	0.00	0.00	0.00	

Submission Printing Options
(For the best print results, please print in 'Landscape' format)

Print Submission Result Print Submission Download Submission Return to Provider Home

Print the Results page (this page) Print the entire Submission Download the Submission in a PDF file Return to the ProviderConnect homepage

Figure 73: CAF Results

14

Save Request as a Draft

This functionality allows a provider to save an authorization request as a work in progress prior to submission. The provider has the option to save the authorization on each tab/page. The draft is maintained on the home page for 30 days. After 30 days, the request is removed and a new request is required.

To save an authorization request as a draft:

1. Click on [Enter an Authorization/Notification Request](#).
2. Click **Next** on the Disclaimer page.
3. Complete the **Member ID** and **Date of Birth** fields and click **Search**.
4. Review the demographic information if necessary and click **Next**.
5. Select the service address and click **Next**.
6. Complete the Requested Services Header.
7. Attach any applicable documents and click **Next**.
8. Click **Save Request as Draft**.

The **Save Request as Draft** button can also be selected on any of the subsequent pages.

The [Authorized User](#) link allows creators of clinical drafts to authorize other users to update and/or submit saved drafts. (Refer to the [Authorized User](#) section at the end of this chapter for detailed information.)

Note

Upon clicking **Save Request as Draft**, a pop-up window displays advising the user how long the draft is available for viewing and modification.

Upon clicking **OK**, the user receives a message stating that the draft request has been successfully saved.

To view saved drafts, click on [View Clinical Drafts](#).

Users can view a read-only version of the draft by clicking the **View** button. To modify or continue with the Request for Authorization, the user may click the **Open** button. To delete a draft, the user may place a checkmark inside the box to the left of the draft and then click the **Delete Request Drafts** button. Clinical Request Drafts that have expired within the last 30 days display at the bottom of the page.

If attachments were added, they need to be reattached when the draft is opened. Attachments do not remain after saving a request as a draft.

Note

Authorized User

Creators of clinical drafts have the ability to allow other users to update and/or submit saved drafts via the [Authorized User](#) link. This functionality applies to all Requests for Services (RFS) workflows, the Individual Care Plan workflow (MRLD parent code), the Wellness Recovery Treatment Plan workflow (BHK parent code), and the Special Program Application and Comprehensive Service Plan workflows (ILL parent code).

If a user is not associated with other users, the **Authorized User** field label is fixed (i.e., static). If only one user was saved, the authorized user ID displays in this field. If multiple users were saved, the word “Multiple” displays in this field.

Following are some of the attributes of this functionality.

- The system will store a record for each authorized user of a saved draft.
- Users who belong to a group will be able to authorize multiple users to a draft.
- When a saved draft is reopened for editing by the originating user, the [Authorized User](#) link will remain available to enable the originating user to access the pop-up to change authorized users.
- A Select Authorized User(s) pop-up window will display a list of users who can be authorized to have access to the originating user’s saved draft request. The pop-up can be accessed from the [Authorized User](#) link when the logged on user is in a group with other users who have clinical access.
 - The user will be able to select authorized users by clicking a checkbox next to each user.
 - The user will have the option to select all associated users.
 - There will be an option to clear all the selected users.
 - The pop-up will display users associated with the logged in user who have clinical access to View/Save Draft Requests.
 - If a user is associated with the logged in user but does not have the appropriate clinical security, that user will not appear in the pop-up.
 - The list will be sorted in ascending order by user ID and cannot be re-sorted.

View Clinical Drafts

The View Clinical Drafts page displays the **Authorized User** field with the updated saved draft information. A read-only pop-up window displays the authorized users associated with a Saved Draft or an Expired Draft (Clinical Request Drafts and Plan Drafts).

15

Enter a Notification

The *Enter a Notification* feature enables providers to electronically submit notifications using the Notification (NTFN) form. The purpose of this form is to meet the data collection and reporting requirements of the Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinic (CCBHC) Grant and to lessen the administrative burden on the providers responsible for creating these notifications/authorizations. That is, the NTFN form allows for an authorization to be generated without requiring clinical information. (Note that not all workflows may have access to this form.)

The NTFN form contains the following tabs.

- Notification
- Results

Contact Information

Contact information is entered first.

- Admitting Physician
- Admitting Physician Phone#
- Attending Physician
- Attending Physician Phone#
- Preparer
- Preparer Phone#
- Utilization Review Contact
- Utilization Review Contact Phone#
- Utilization Review Contact Fax

Primary Care Coordination Information

Primary care coordination information is entered next.

- PCP Contacted Status

Note: If the PCP contacted status is either **Care Plan Sent to PCP** or **PCP Contacted**, the PCP contact name and date are required.

- PCP Contacted Name
- Date Contacted

Diagnosis Information

Diagnosis information is entered last.

- Behavioral Diagnoses
- Primary Medical Diagnosis
- Social Elements Impacting Diagnosis
- Functional Assessment

(Refer to the [Diagnosis](#) section of the [Enter an Authorization Request \(RFS\)](#) chapter for detailed information.)

Additional Information

The form also includes a 2,000-character text field for the user to provide any additional information that would be helpful in processing the request.

Clicking **Submit** redirects the user to the Determination Status page.

16

Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge

Providers have the ability to easily submit concurrent reviews, step/transfer reviews, and discharges via the [Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge](#) link. This link displays on the ProviderConnect home page if the provider has any authorizations that expired within the last 90 days or are expiring in 90 days. Note that:

- If there are no authorization records for the provider at all, this link does not display.
- If there are authorizations for the provider but none with an expiration date that falls within the 180-day span, the link displays, but the provider receives a message indicating there are no records to display.
- If this feature has been disabled for all parent codes for which the provider has authorizations, this link does not display.

Upon clicking this link, a subset of the provider's authorizations displays on the Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge page. Any inpatient or outpatient authorizations that expired within the last 90 days or are expiring in 90 days will be listed on this page in descending order by expiration date. Be aware, however, that if all the authorization detail lines for a particular authorization contain a reason code of VVO (Void) or if the authorization has been suppressed in Service/CareConnect, the authorization will not display. If this feature has been disabled for a particular parent code, then any authorizations associated with that parent code will not display.

The date range can be changed for which the provider wishes to see authorizations by changing the authorization expiration from/to dates. Results can be sorted by:

- Auth #
- Client Auth #
- Effective Date
- Expiration Date
- Level of Service
- Type of Service
- Level of Care
- Type of Care

The Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge page contains the following action buttons.

- **Process Concurrent Review**

***Note:** Selecting this option does not necessarily mean the review will be a concurrent review. It could be an initial review depending on what occurs in the application upon clicking **Next** on the Requested Services Header page.*

- **Process Step/Transfer Review**

***Note:** This button is disabled for outpatient authorizations.*

- **Enter Discharge Information**

***Note:** Activates the discharge information workflow. This button will be disabled if the authorization has already been discharged. It will also be disabled for any psychological testing authorizations.*

Upon selecting an authorization and starting either a concurrent or step/transfer review, the following pop-up window displays.

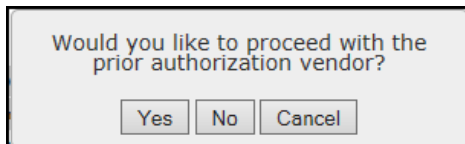


Figure 74: Proceed with the prior authorization vendor?

- Yes – Bypasses the vendor selection page. Instead of the user choosing a vendor, the system uses the vendor from the selected authorization for the new request. Certain fields pre-populate automatically on the Requested Services Header page depending on whether the user is performing a concurrent or a step/transfer review.
- No – Displays the standard Select Service Address page.
- Cancel – Closes the window.

Process an Initial Review, Concurrent Review, Step/Transfer Review, or Discharge

Upon starting an authorization/notification request from either the ProviderConnect home page or member demographics, the Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge page displays if the member/provider combination has any inpatient or outpatient authorizations that expired within the last 90 days or are expiring in 90 days.

Note: If this feature has been disabled for the member's parent code, this page does not display regardless of whether the member/provider combination has any inpatient or outpatient authorizations that expired within the last 90 days or are expiring in 90 days.

This page contains the following action buttons.

- **Process Initial Review**

Note: Selecting this option does not necessarily mean the review will be an initial review. It could be a concurrent review, depending on what occurs in the application upon clicking **Next** on the Requested Services Header page.

- **Process Concurrent Review**

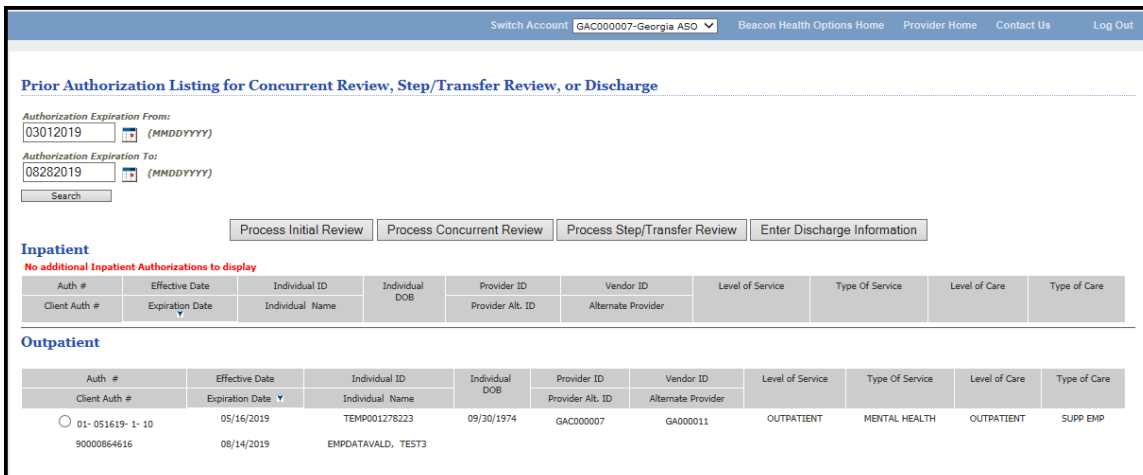
Note: Selecting this option does not necessarily mean the review will be a concurrent review. It could be an initial review, depending on what occurs in the application upon clicking **Next** on the Requested Services Header page.

- **Process Step/Transfer Review**

Note: This button is disabled for outpatient authorizations.

- **Enter Discharge Information**

Note: Activates the discharge information workflow. This button will be disabled if the authorization has already been discharged. It will also be disabled for any psychological testing authorizations.



Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge

Authorization Expiration From: 03/01/2019 (MMDDYYYY)

Authorization Expiration To: 08/28/2019 (MMDDYYYY)

Search

Process Initial Review Process Concurrent Review Process Step/Transfer Review Enter Discharge Information

Inpatient

No additional Inpatient Authorizations to display

Auth #	Effective Date	Individual ID	Individual DOB	Provider ID	Vendor ID	Level of Service	Type Of Service	Level of Care	Type of Care
Client Auth #	Expiration Date	Individual Name	Provider Alt. ID	Alternate Provider					
01-051619-1-10	05/16/2019	TEMP001278223	09/30/1974	GAC000007	GAC000011	OUTPATIENT	MENTAL HEALTH	OUTPATIENT	SUPP EMP
90000864616	08/14/2019	EMPDATAVALD, TEST3							

Outpatient

Auth #	Effective Date	Individual ID	Individual DOB	Provider ID	Vendor ID	Level of Service	Type Of Service	Level of Care	Type of Care
Client Auth #	Expiration Date	Individual Name	Provider Alt. ID	Alternate Provider					
01-051619-1-10	05/16/2019	TEMP001278223	09/30/1974	GAC000007	GAC000011	OUTPATIENT	MENTAL HEALTH	OUTPATIENT	SUPP EMP
90000864616	08/14/2019	EMPDATAVALD, TEST3							

Figure 75: Process an Initial Review, Concurrent Review, Step/Transfer Review, or Discharge

Process a Concurrent Review, Discharge Review, or Step/Transfer Review

The Auth Summary and Auth Details pages also contain the following action buttons.

Note: If this feature has been disabled for the member's parent code, these buttons do not display.

- **Process Concurrent Review**

Note: Selecting this option does not necessarily mean the review will be a concurrent review. It could be an initial review, depending on what occurs in the application upon clicking *Next* on the Requested Services Header page.

- **Complete Discharge Review**

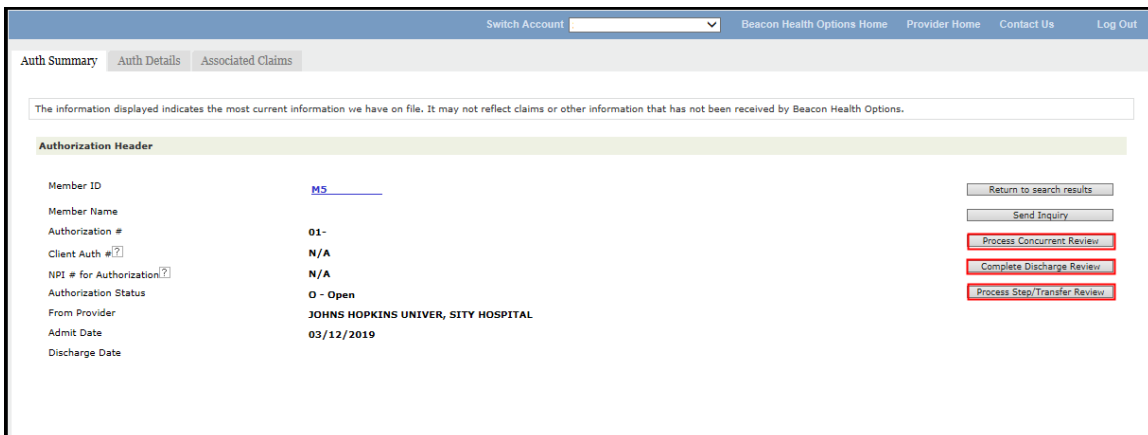
Note: Activates the discharge information workflow. This button will be disabled if the authorization has already been discharged. It will also be disabled for any psychological testing authorizations.

- **Process Step/Transfer Review**

Note: This button is disabled for outpatient authorizations.

The **Process Concurrent Review** and **Process Step/Transfer Review** buttons are disabled:

- For any psychological testing authorizations,
- For any authorizations that have a level of service other than inpatient or outpatient (e.g., EAP), or
- If the Prior Authorization Listing for Concurrent Review, Step/Transfer Review feature has been disabled for the member's parent code.



Switch Account [v] Beacon Health Options Home Provider Home Contact Us Log Out

Auth Summary Auth Details Associated Claims

The information displayed indicates the most current information we have on file. It may not reflect claims or other information that has not been received by Beacon Health Options.

Authorization Header

Member ID	MS	Return to search results
Member Name		Send Inquiry
Authorization #	01-	Process Concurrent Review
Client Auth # [?]	N/A	Complete Discharge Review
NPI # for Authorization [?]	N/A	Process Step/Transfer Review
Authorization Status	O - Open	
From Provider	JOHNS HOPKINS UNIVER, SITY HOSPITAL	
Admit Date	03/12/2019	
Discharge Date		

Figure 76: Process a Concurrent Review, Discharge Review, or Step/Transfer Review

17

Recent Provider Summary Vouchers

Users can view recent provider summary vouchers by clicking on [View My Recent Provider Summary Vouchers](#).

Provider summary vouchers can be retrieved by:

- Searching Provider Summary Vouchers by Provider

Note: This is the default.

- Searching Provider Summary Vouchers by Check

The search results contain records that match the search criteria. A specific provider summary voucher can be viewed by clicking on the [View](#) link.

[Home](#)
[Specific Member Search](#)
[Register Member](#)
[Authorization Listing](#)
[Enter an Authorization Request](#)
[View Clinical Drafts](#)
[Claim Listing and Submission](#)
[Enter EAP CAF](#)
[Review Referrals](#)
[Enter Bed Tracking Information](#)
[Search Beds/Openings](#)
[EDI Homepage](#)
[Enter Member Reminders](#)
[On Track Outcomes](#)
[Reports](#)
[Print Spectrum Release of Information Form](#)
[My Online Profile](#)
[My Practice Information](#)
[Provider Data Sheet](#)
[Compliance](#)
[Handbooks](#)
[Forms](#)
[Network Specific Information](#)
[Education Center](#)
[ValueSelect Designation](#)
[Contact Us](#)

[Search By Provider](#)
[Search By Check](#)

[Search Provider Summary Voucher by Provider](#)

Provider ID ?

Search All Providers

Tax ID ?

OR

Vendor ID ?

Check #

(No spaces or alpha characters)

Paid Date Range ?

From 05/01/2014

Through 08/31/2014

(MM/DD/YYYY)

Search

[Provider Summary Voucher Search Results](#)

Click on View to see the Provider Summary Voucher.

Select	Vendor Name	Vendor Number	Paid Date	Check Number	Check Amount
View	SHEPPARD PRATT PHYSI	A006879	08/26/14	0000216208	50946.83
View	SHEPPARD PRATT PHYSICIANS PA	A516455	08/26/14	0000216329	3124.32
View	SHEPPARD PRATT PHYSI	A006879	08/19/14	0000215130	50405.80
View	SHEPPARD PRATT PHYSICIANS PA	D349501	08/19/14	0000216005	1789.10
View	SHEPPARD PRATT PHYSICIANS PA	A516455	08/19/14	0000215279	1263.32
View	SHEPPARD PRATT PHYSICIANS PA	D349501	08/18/14	0000021066	111.20
View	SHEPPARD PRATT PHYSI	D337640	08/15/14	0000064624	395.22
View	SHEPPARD PRATT PHYSI	A006879	08/12/14	0000214142	39027.53
View	SHEPPARD PRATT PHYSICIANS PA	D349501	08/12/14	0000215005	329.08
View	SHEPPARD PRATT PHYSICIANS PA	A516455	08/12/14	0000214260	2509.97
View	SHEPPARD PRATT PHYSICIANS PA	D356180	08/08/14	0000062568	66.00
View	SHEPPARD PRATT PHYSI	D337640	08/08/14	0000062555	486.00
View	SHEPPARD PRATT PHYSI	A006879	08/05/14	0000213146	34291.55
View	SHEPPARD PRATT PHYSICIANS PA	D349501	08/05/14	0000214016	563.46
View	SHEPPARD PRATT PHYSICIANS PA	A516455	08/05/14	0000213255	1172.18
View	SHEPPARD PRATT PHYSICIANS PA	A516455	08/05/14	0000213255	1172.18
View	SHEPPARD PRATT PHYSI	A006879	07/29/14	0000212259	21056.07
View	SHEPPARD PRATT PHYSICIANS PA	D349501	07/29/14	0000213039	5224.19
View	SHEPPARD PRATT PHYSI	A006879	07/22/14	0000211155	33434.07
View	SHEPPARD PRATT PHYSICIANS PA	D349501	07/22/14	0000212132	107.34
View	SHEPPARD PRATT PHYSICIANS PA	A516455	07/22/14	0000211287	4034.97
View	SHEPPARD PRATT PHYSI	D337640	07/18/14	0000059708	115.20
View	SHEPPARD PRATT PHYSI	A006879	07/15/14	0000210082	38912.27

Figure 77: Search a Provider Summary Voucher

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Claim Listing and Submission

In this section of ProviderConnect, a user can enter a claim, submit a claim, and search for a claim.

Upon clicking either [Claim Listing and Submission](#) or [Review a Claim](#), the Claims page displays with three sections titled New Claims, Search Claims, and Search Other Claims.

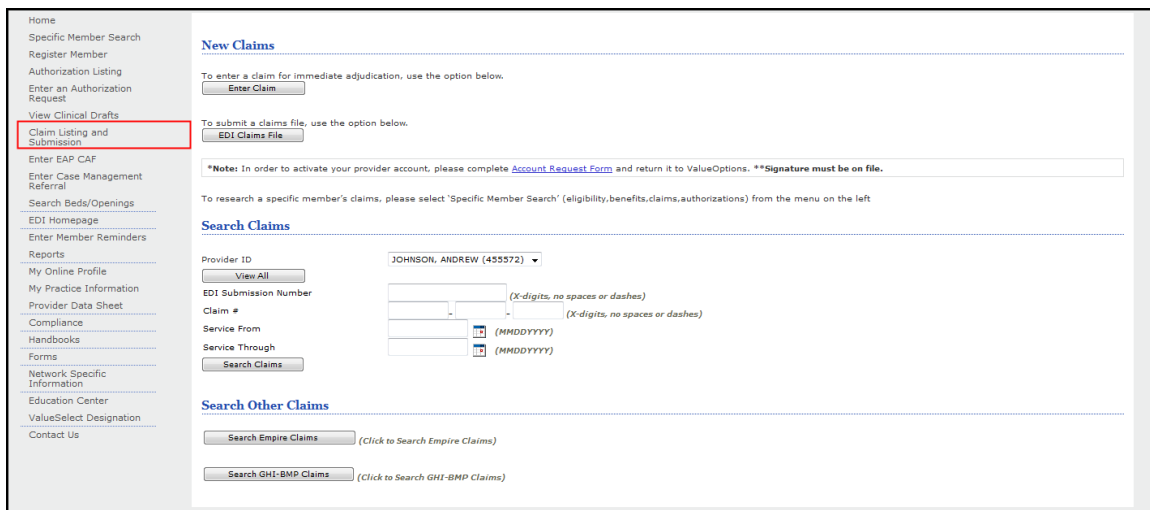


Figure 78: Claims

This page contains several options.

- Click the **Enter Claim** button to enter a claim for immediate adjudication. For detailed information, refer to the [Enter a Claim](#) section.

Note:

- *Providers need their vendor number. This number can be obtained from Provider Relations.*
- *Name fields are not required. If a name is entered, make sure the spelling is correct or an error message displays.*
- *The patient's date of birth must be entered, not the member's date of birth.*

- Click the **EDI Claims File** button to submit an electronic claim. For detailed information, refer to the [EDI Homepage](#) chapter.
- Complete the Search Claims section and click **Search** to search for a provider-specific claim. For detailed information, refer to the [View Member Claims](#) section.
- Click the **Search Empire Claims** button if the claim is specific to the Empire Client. For detailed information, refer to the [View Empire Claims](#) section.

- Click the **Search GHI-BMP Claims** button if it is a GHI-BMP claim. For detailed information, refer to the [View GHI-BMP Claims](#) section.

Slight differences appear between the directions in the referenced sections and the directions for Claims Listing and Submission (because the information is member-specific instead of provider-specific). The majority of the directions are the same, however.

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Viewing OnTrack Outcomes

The [View My Outcomes with On Track](#) link gives providers the ability to have seamless connectivity to the OnTrack Outcomes Tools on the Collaborative Outcomes Resource Network (ACORN). The Beacon Health Options *OnTrack* program is a client-centered outcomes-informed care program. The goal of *OnTrack* is to provide clinicians with state-of-the-art easy to use tools that promote improved client outcomes. *OnTrack* is designed to support clinicians as they help their clients achieve their goals. Beacon clinicians can use *OnTrack* for all of their EAP, commercially insured or private pay clients, including, if they choose, those clients who are not Beacon members.

Upon clicking either **On Track Outcomes** or **View My Outcomes with On Track**, the On Track Outcomes Tool displays.

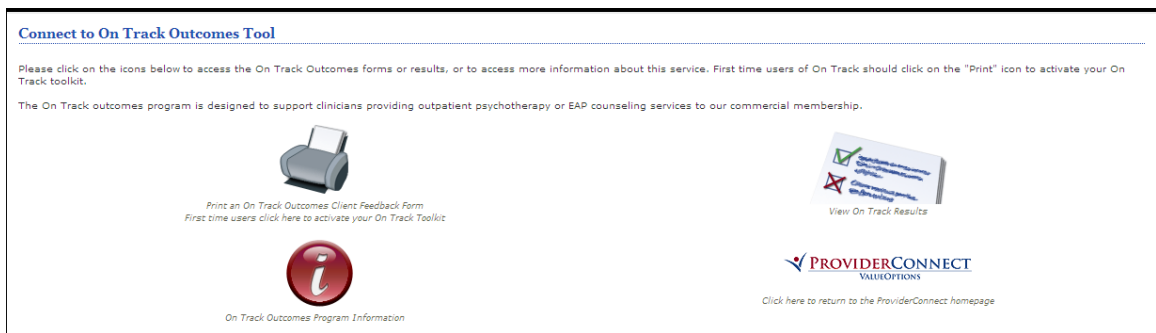


Figure 79: OnTrack Outcomes Tool

To view OnTrack program information, click the **On Track Outcomes Program Information** icon.

The OnTrack Toolkit is hosted for Beacon Health Options on the ACORN (A Collaborative Outcomes Resource Network) platform. The ACORN site contains a variety of outcomes forms that can be viewed and printed.

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My Online Profile

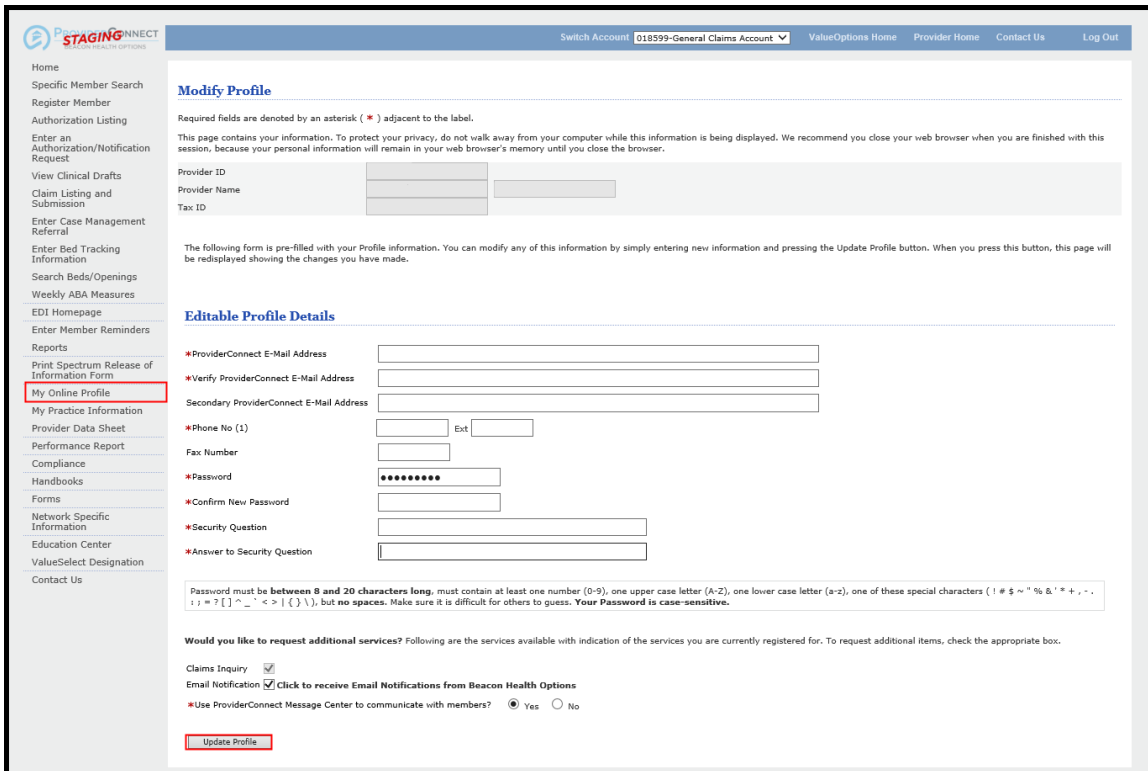
In this section of ProviderConnect, providers can access and modify their own profile information.

Upon clicking [My Online Profile](#), a page displays that contains the following sections.

- The Modify Profile section contains information that cannot be changed (e.g., Provider ID, Provider Name, and Tax ID).
- In the Editable Profile Details section, however, the user can edit information (e.g., E-mail Address, Phone Number, and Password).

To edit provider information:

1. Update the information in the Editable Profile Details section as appropriate.
2. Click **Update Profile**.



Modify Profile

Required fields are denoted by an asterisk (*) adjacent to the label.

This page contains your information. To protect your privacy, do not walk away from your computer while this information is being displayed. We recommend you close your web browser when you are finished with this session, because your personal information will remain in your web browser's memory until you close the browser.

Provider ID
Provider Name
Tax ID

The following form is pre-filled with your Profile information. You can modify any of this information by simply entering new information and pressing the Update Profile button. When you press this button, this page will be redisplayed showing the changes you have made.

Editable Profile Details

*ProviderConnect E-Mail Address
*Verify ProviderConnect E-Mail Address
Secondary ProviderConnect E-Mail Address
*Phone No (1)
Fax Number
*Password
*Confirm New Password
*Security Question
*Answer to Security Question

Password must be **between 8 and 20 characters long**, must contain at least one number (0-9), one upper case letter (A-Z), one lower case letter (a-z), one of these special characters (! # \$ % ^ & ' * + , - . : ; = ? [\] ^ _ ` { | } ~), but **no spaces**. Make sure it is difficult for others to guess. **Your Password is case-sensitive.**

Would you like to request additional services? Following are the services available with indication of the services you are currently registered for. To request additional items, check the appropriate box.

Claims Inquiry ☒
Email Notification ☒ Click to receive Email Notifications from Beacon Health Options
*Use ProviderConnect Message Center to communicate with members? ☒ Yes ☐ No

Update Profile

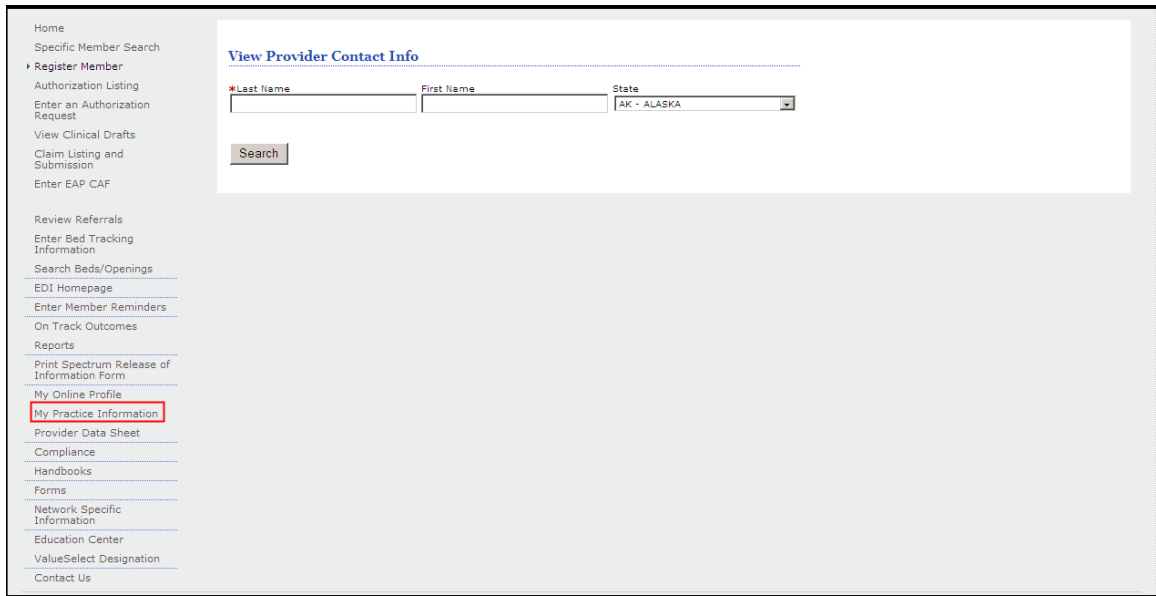
Figure 80: My Online Profile

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My Practice Information

In the *My Practice Information* section of ProviderConnect, information on provider practices can be accessed.

Click on [My Practice Information](#) to view provider contact information.



Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
View Clinical Drafts
Claim Listing and Submission
Enter EAP CAF
Review Referrals
Enter Bed Tracking Information
Search Beds/Openings
EDI Homepage
Enter Member Reminders
On Track Outcomes
Reports
Print Spectrum Release of Information Form
My Online Profile
My Practice Information
Provider Data Sheet
Compliance
Handbooks
Forms
Network Specific Information
Education Center
ValueSelect Designation
Contact Us

View Provider Contact Info

*Last Name First Name State
 AK - ALASKA

Figure 81: View Provider Contact Information

1. Enter the provider's last name in the **Last Name** field.
2. Enter provider's first name, if needed, in the **First Name** field.
3. Select a state, if needed, from the **State** drop-down.
4. Click **Search**.

The Provider Search Results page displays.

5. Click on the [Last Name](#) for the appropriate provider.

Provider Search Results					
Click on Last Name for more details.					
Last Name	First Name	Provider ID	Vendor ID	Provider Description	Address/ Phone
SMITH	DOUGLAS	UAW215261	U215258	Psychiatrist & Medical Doctor	415 6TH ST,STE G16 JUNEAU AK 99801 (907) 523-8120 X
SMITH	DOUGLAS	UAW215480	U215477	Psychiatrist & Medical Doctor	201 LINCOLN ST,STE 1 SITKA AK 99835 (907) 747-3743 X
SMITH	DOUGLAS	UAW430155	U430150	Psychiatrist & Medical Doctor	113 METLAKATLA ST, SITKA AK 99835 (907) 747-3636 X
SMITH	HAROLD	UAW445590	U445585	Psychologist, Doctoral Level	3105 LAKESHORE DR,STE B102 ANCHORAGE AK 99517 (907) 330-9669 X

Figure 82: Provider Search Results

The Provider Details page displays. Detailed information about the provider displays on this page (e.g., Name, Address, Specialties).

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Provider Data Sheet

The Provider Data Sheet (PDS) is Beacon's online provider re-credentialing application and is accessible to providers only at the time re-credentialing is needed. Providers are notified via telephone, fax, e-mail, or mail when re-credentialing is due and the PDS is available.

To access this section, click the [Provider Data Sheet](#) link on the navigation bar. The PDS contains the following tabs.

- Provider
- Referral
- Practice
- Education
- License/Certification
- Insurance
- Work History
- EAP Counselor
- Disability Provider
- FFD Specialist
- Provider Profile
- W-9
- Supporting Documentation
- Attestation

1. Review the Provider Information, and make any necessary corrections or additions. Click **Save & Next** to continue.

Note: A red asterisk (*) indicates a required field.

(Required fields are indicated by *)

1. PROVIDER INFORMATION

A. DEMOGRAPHIC INFORMATION

Last Name* First Name* MI Gender* ☒ Female ☐ Male

Mailing Address Line 1* Mailing Address Line 2 US Citizen* ☐ Yes ☐ No

City* State* Zip*

Fax: (include area code) Ext: Telephone: (include area code)* Ext: NPI Number

Mobile Phone Pager

Social Security Number* Date of Birth* Professional Designation or Title*

Indicate any other name you may have used in the past (e.g., maiden name, etc.) Internet E-mail address*

Highest Level of Licensure/Certification*

Additional Licensure/Certification

Figure 83: Provider Information

2. Enter the necessary Referral Information. Click **Save & Next** to continue.

2. REFERRAL INFORMATION

A. LICENSED DISCIPLINE: Indicate the discipline under which you are LICENSED and/or CERTIFIED at the highest level to practice independently.

- | | |
|---|--|
| <input type="checkbox"/> APN W/ Prescriptive Authority | <input type="checkbox"/> Licensed Professional Counselor/Mental Health Counselor (Highest level) |
| <input type="checkbox"/> APN W/O Prescriptive Authority | <input type="checkbox"/> Licensed/Certified Social Worker (Highest level) |
| <input type="checkbox"/> Addictionologist | <input type="checkbox"/> MD Developmental Behavioral Pediatrician |
| <input type="checkbox"/> Alcohol/Drug/Substance Abuse Counselor | <input type="checkbox"/> Master's Level Psychologist |
| <input type="checkbox"/> Art Therapist | <input type="checkbox"/> Other Psychologist |
| <input type="checkbox"/> Child Psychiatrist | <input type="checkbox"/> Other Social Worker (Not at highest level) |
| <input type="checkbox"/> Child/Adolescent Psychiatrist | <input type="checkbox"/> Other with ability to specify |
| <input type="checkbox"/> Developmental Behavioral Pediatrician | <input type="checkbox"/> Pastoral Counselor |
| <input type="checkbox"/> EAP | <input type="checkbox"/> Physician - Non Psychiatrist |
| <input type="checkbox"/> Geriatrics Psychiatrist | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> LIC/CERT Psychological Examiner | <input type="checkbox"/> Psychiatric Clinical Nurse Specialist |
| <input type="checkbox"/> LLP- Limited License Psychologist | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Licensed Clinical Psychologist (Doctorate level) | <input type="checkbox"/> Qualified Mental Health Practitioner (Nebraska) |
| <input type="checkbox"/> Licensed Clinical Social Worker (Highest level) | <input type="checkbox"/> Unlicensed Provider |
| <input type="checkbox"/> Licensed Marriage and Family Therapist (Highest level) | |

Other (specify):

B. Population Treated:

Identify the percentage of your practice dedicated to the following patient population categories (must total 100%).

Population	% of Practice	Are You Currently Accepting New Patients?		Modality	% of Practice
		Yes	No		
Child(0-5)	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	Inpatient	<input type="text"/>
Child(6-12)	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	Day Treatment	<input type="text"/>
Adolescent(13-17)	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	Outpatient	<input type="text"/>
Adult(18-64)	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	Intensive Outpatient Programs	<input type="text"/>
Geriatric(65+)	<input type="text"/>	<input type="radio"/>	<input type="radio"/>		
Total: 0%		Total: 0%			

Total: 0%

Total: 0%

C. Language:

Identify any foreign language(s) or sign language that you use fluently in treating patients (select no more than 5):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ARABIC | <input type="checkbox"/> GUJARATHI | <input type="checkbox"/> NONE | <input type="checkbox"/> SUDANESE |
| <input type="checkbox"/> ARMENIAN | <input type="checkbox"/> HAITIAN CREOLE | <input type="checkbox"/> NORWEGIAN | <input type="checkbox"/> SWEDISH |
| <input type="checkbox"/> BOSNIAN | <input type="checkbox"/> HEBREW | <input type="checkbox"/> PERSIAN | <input type="checkbox"/> TAGALOG |
| <input type="checkbox"/> CANTONESE | <input type="checkbox"/> HINDI | <input type="checkbox"/> POLISH | <input type="checkbox"/> TAGALOG (FILIPINO) |
| <input type="checkbox"/> CHINESE | <input type="checkbox"/> HUNGARIAN | <input type="checkbox"/> PORTUGUESE | <input type="checkbox"/> TAMIL |
| <input type="checkbox"/> CZECH | <input type="checkbox"/> ITALIAN | <input type="checkbox"/> RUSSIAN | <input type="checkbox"/> THAI |
| <input type="checkbox"/> DUTCH | <input type="checkbox"/> JAPANESE | <input type="checkbox"/> SERBO-CROATIAN | <input type="checkbox"/> UNKNOWN |
| <input type="checkbox"/> FARSI (PERSIAN) | <input type="checkbox"/> KANNADA | <input type="checkbox"/> SIGN LANGUAGE | <input type="checkbox"/> URDU |
| <input type="checkbox"/> FRENCH | <input type="checkbox"/> KOREAN | <input type="checkbox"/> SOMALI | <input type="checkbox"/> VIETNAMESE |
| <input type="checkbox"/> GERMAN | <input type="checkbox"/> MANDARIN | <input type="checkbox"/> SPANISH | <input type="checkbox"/> YIDDISH |
| <input type="checkbox"/> GREEK | <input type="checkbox"/> NON-KHMER | | |

Other (specify):

D. ANSWERING SERVICE:

Indicate how you can be reached after hours:

Answering Service Name* ☐ Check box for No Answering Service (Self)

Phone #* Ext: Pager or Beeper # Ext:

Voice Mail # Ext:

E. CLINICAL EXPERTISE (SPECIALTIES): From the list below, rank order a maximum of six (6) specialty areas for which you have training and expertise. For example "1" means primary specialty, "2" means secondary specialty, etc. If you indicate more than six specialties, they will not be documented. These specialties will be used to assist ValueOptions®, Inc. in making clinically appropriate referrals. Please remember to select applicable specialties when applying for the specialty networks.

- Select Specialty --
- Select Specialty --
- Select Specialty --
- Select Specialty --
- Select Specialty --
- Select Specialty --

F. THERAPEUTIC MODALITIES: From the list below, rank order a maximum of six (6) modality areas that you use when treating patients. For example "1" means primary modality, "2" means secondary, etc. These modalities will be used to assist ValueOptions®, Inc. in making clinically appropriate referrals. Please remember to select applicable modalities when applying for the specialty networks.

- Select Specialty --
- Select Specialty --
- Select Specialty --
- Select Specialty --
- Select Specialty --
- Select Specialty --

G. VOLUNTARY INFORMATION: To meet the needs of ValueOptions®, Inc. clients and members, voluntary information is maintained about providers for referral and statistical purposes only. This information is released to members only upon specific request. If you wish to provide this information, select from the following categories:

-- Select Ethnicity --

H. HOSPITAL PRIVILEGES (Physicians Only): List below, if applicable, your current hospital privileges and the type of hospital privilege granted to you by your admitting facility. The Primary Admitting Facility should be the facility at which you admit/treat most of your patients.

Do you currently hold hospital privileges? ☐ Yes ☐ No

Edit Name Address City/ST/Zip Delete

No Records Found



Add Hospital Privilege

If you **do not** have admitting privileges, list the name(s) of an in-network physician or facility below to whom you would refer.

First Name Last Name Facility Name


* You may call the National Network Services Line at (800) 397-1630 to verify network participation.

Figure 84: Provider Referral Information

3. Enter the provider's Practice Information. Click **Save & Next** to continue.


3. PRACTICE INFORMATION

A. PRACTICE INFORMATION
 No records are currently attached to this provider

 **Add Additional Practice Location**

B. DEMOGRAPHIC DATA:
 ValueOptions®, Inc., is contracted with various public agencies at the Federal, State and Local levels. Some of these contracts require us to verify the business size of our Network providers/facilities as well as their socioeconomic status. The collection of this data will not be used for credentialing purposes. This information will be used in aggregate to supply data to the Federal or State government as part of a government contracting process. **These questions should be answered considering the Group TIN in which claims are filed if you are part of a Group. If you are an individual practitioner/sole proprietor, the questions should be answered based on the TIN in which you file your claims.** In order to assist us in facilitating this process, we ask you complete the questions below for the TIN in which your claims are filed.

 What is the North American Industrial Classification System Code (NAICS) for this business?
 -- Select NAICS Code --
 If not listed in drop-down selection list above, please enter the NAICS that matches your companies concern here:
 Other (specify):

Click here  for some of the common NAICS codes for providers of healthcare services with their applicable average annual size standard. If your business type is not listed below, contact the Small Business Administration in your area for assistance or for a complete listing of all NAICS codes, please visit <https://www.sba.gov/size>.

This information is for demographic reporting purposes only and will not be used for credentialing. This information may be used in the aggregate to supply data to the federal or state government as part of a government contracting process. **The information will be disclosed only for the purposes stated.**
 If this information is applicable to your business, please answer the following questions.

Are you an employee of a professional or other corporation? ☐ Yes ☐ No

Is this business considered a small business as defined by the Small Business Administration? ☐ Yes ☐ No

• **Small Business** means a concern that is independently owned and operated, not dominant in the field of operation in which it is operating under Government Contracts and meets size standards set by the Small Business Administration (SBA). Small Business size varies by NAICS, see chart above. The number of employees or annual gross revenue indicates the maximum allowed for a concern to be considered a small business. Small Business size examples: A business is considered small business if its annual gross revenues (an average for the last three years) are less than the amount specified for its NAICS number (see above section for examples).

Is this business considered a Women-Owned Small Business? ☐ Yes ☐ No


• **Woman Owned Small Business** means a concern that is at least 51 percent owned by one or more women and whose management and daily business operations are controlled by one or more women and meets size standards to be considered small (see above).

Is this business considered a Small Disadvantaged Business? ☐ Yes ☐ No

• **Small Disadvantaged Business** means a concern that is at least 51 percent owned by a disadvantaged person(s) and that person(s) provides daily management and control of the firm. The following are considered disadvantaged groups (all must be U.S. citizens): Black Americans; Hispanic Americans; Native Americans (American Indians, Eskimos, Aleuts, and Native Hawaiians); Asian Pacific Americans (persons with origins from Japan, China, the Philippines, Vietnam, Korea, Samoa, Guam, U.S. Trust Territory of the Pacific Islands [Republic of Palau], Commonwealth of the Northern Mariana Islands, Laos, Cambodia [Kampuchea], Taiwan; Burma, Thailand, Malaysia, Indonesia, Singapore, Brunei, Republic of the Marshall Islands, Federated States of Micronesia, Macao, Hong Kong, Fiji, Tonga, Kiribati, Tuvalu, or Nauru); Subcontinent Asian Americans (persons with origins from India, Pakistan, Bangladesh, Sri Lanka, Bhutan, the Maldives Islands or Nepal), and Members of other groups designated by the SBA. Individual/concern other than one of the proceeding, currently certified for participation in the Minority Small Business and Capital Ownership Development Program under section 8 (a) of the Small Business Act.

Is this business considered 8(a) certified? If yes, please include copy of certification. ☐ Yes ☐ No

• **8(a) Certified** means a concern that has received a certification for this Program from the Small Business Administration.

 **Upload 8(a) Certificate**

Is this business considered a Veteran-Owned Small Business? ☐ Yes ☐ No


• **Veteran Owned Small Business** means a concern that is at least 51 percent owned by one or more veterans and whose management and daily business operations are controlled by one or more veterans and meets size standards to be considered small (see above).

Is this business considered a Service Disabled Veteran-Owned Small Business? ☐ Yes ☐ No

• **Service-Disabled Veteran-Owned Small Business** means a concern owned and controlled by a service disabled veteran. The term "service-disabled veteran" means a veteran with a disability that is service connected (as defined in section 101 (16) of title 38, United States Code) and meets size standards to be considered small.

Is this business considered a HUBZone Small Business? If yes, please include copy of certification. ☐ Yes ☐ No

• **HUBZone Small Business** A firm can be found to be a qualified HUBZone concern, if it is small; it is located in an "historically underutilized business zone" (HUBZone); it is owned by one or more U.S. Citizens; at least 35 percent of its employees reside in a HUBZone. Must be certified by the U.S. Small Business Administration (SBA). SBA in your area can help to determine if you're located in a HUBZone and help you receive certification. Copy of the certification needs to be submitted with your credentialing application.

 **Upload HUBZone Certificate**

Is this business considered a large business as defined by the Small Business Administration? ☐ Yes ☐ No

• **Large Business** means a concern that does not qualify for a small business as defined above.

Is this business considered a Historically Black College/Minority Institution? ☐ Yes ☐ No

• **Historically Black college** means institutions determined by the Secretary of Education to meet the requirements of 34 CFR 608.2. The term also means any nonprofit research institution that was an integral part of such college or university before November 14, 1986. Minority Institution means institution of higher education meeting the requirements of section 1046(3) of the Higher Education Act of 1965 (20 USC 1135d-5 (3)); Enrollment of a single minority or a combination of minorities exceeds 50 percent of the total enrollment. The term also includes Hispanic serving institutions as defined in section 316(8) (1) of such Act (20 USC 1059c(b)).

If your business could be classified as a minority-owned business, which of the following categories would it fall under?
 This question is optional.

<input type="radio"/> Caucasian	<input type="radio"/> Hispanic (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
<input type="radio"/> Black (African, Jamaican or West Indian descent)	<input type="radio"/> Asian or Pacific Islander (persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent of the Pacific Islands)
<input type="radio"/> Native American or Alaskan Native (Persons having origins in any of the original peoples of America)	

Figure 85: Provider Practice Information

4. Enter the provider's Education Information. Click **Save & Next** to continue.


4. EDUCATION INFORMATION Required for verification purposes)

Educational Degrees:

A. EDUCATION INFORMATION


Edit Type
Institution
Degree
Start
End
Delete

No Records Found



If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No


* If the answer is yes, please include a copy of your certificate. If you have an electronic copy of your certificate, please use the Upload ECFMG button. If you have a paper copy of your certificate, please fax it to 1-866-612-7795.




B. CONTINUING EDUCATION: This section is required for EAP Applicants Only. List any continuing education seminars/workshops you have attended in the past 24 months. Please **upload a copy** of CEU/PDH certificate(s) of completion or you may attach a copy of your Accredited Continuing Education Agency's Report, if applicable. If you do not have electronic copies of either your CEU/PDH certificate or your Accredited Continuing Education Agency's Report, please fax the paper copies to 1-866-612-7795.

Edit Course
Sponsor
CEUs
Title
Date
Completed
Delete

No Records Found








Figure 86: Provider Education Information


5. Enter the provider's License/Certification Information, and upload or fax a copy of his/her current certificate(s). Click **Save & Next** to continue.

5. LICENSE/CERTIFICATION INFORMATION


A. PROFESSIONAL LICENSE(S): Please identify in the list below, **all** health care licenses held in the past ten- (10) years. Indicate original licensure date through current expiration date for each state in which you are or have been licensed/certified. Please provide an explanation for any license that is no longer current, whether by voluntary relinquishment or disciplinary or other action. If you are unable to upload this document, please fax to 1-866-612-7795.

[Edit](#) [Type](#) [Certifying](#) [Entity](#) [State](#) [Issued](#) [Delete](#)

No Records Found



For each license/certification you hold, you will need to click the Add License/Certification button to input your information.



How many years do you have of post-license clinical experience in the direct provision of mental health/substance abuse care? Years of managed care experience?

B. BOARD CERTIFICATION SPECIALTY: List below any certifications you have received from any nationally recognized specialty boards.

Name of Board (if board certified)

PRINCIPAL SPECIALTY

Exam Information (check one):

☐ Oral exam taken ☐ Oral exam scheduled ☐ Written exam taken

☐ Written exam scheduled ☐ No plans to take exam

Exam Date: (MM/DD/YYYY) Date Certified: (MM/DD/YYYY) Re-exam Date: (MM/DD/YYYY)

Name of Board (if board certified)

SECONDARY SPECIALTY

Exam Information (check one):

☐ Oral exam taken ☐ Oral exam scheduled ☐ Written exam taken


☐ Written exam scheduled ☐ No plans to take exam

Exam Date: (MM/DD/YYYY) Date Certified: (MM/DD/YYYY) Re-exam Date: (MM/DD/YYYY)

C. ADDITIONAL CERTIFICATIONS: List below any certifications you have received from any nationally recognized specialty boards.

Certification Type	Certificate #	Expiration Date
American Nursing Credentialing Center (ANCC) Board Certification (i.e. APRN, BC)	<input type="text"/>	<input type="text"/> (MM/DD/YYYY)
American Board of Examiners in Clinical Social Work (ABECSW)	<input type="text"/>	<input type="text"/> (MM/DD/YYYY)
Certified Employee Assistance Professional (CEAP)	<input type="text"/>	<input type="text"/> (MM/DD/YYYY)
Chemical Dependency Certification (Specify):	<input type="text"/>	<input type="text"/> (MM/DD/YYYY)

Please include a current copy of your certification with your application materials.



If you are unable to upload this document, please fax to 1-866-612-7795.

D. ADVANCED PRACTICE NURSE (APN only)

Are you currently recognized by your state licensing board to practice as an Advanced Practice Nurse? ☐ Yes ☐ No

Do you hold prescriptive authority in the state(s) in which you are licensed to practice? ☐ Yes ☐ No

Are you required by your licensing board to hold a collaboration agreement with a physician? ☐ Yes ☐ No

Does your licensing board require you to be supervised by a physician? ☐ Yes ☐ No

If you are required to collaborate or be supervised by a physician, is the physician a psychiatrist? ☐ Yes ☐ No

Do you have a Federal DEA certificate? ☐ Yes ☐ No

Do you hold a state issued Controlled Dangerous Substance (CDS) Registration or Rx #? ☐ Yes ☐ No

This section to be completed by APN's who are required to collaborate or be supervised by a physician.

Name of collaborating/supervising physician:


Specialty of collaborating/supervising physician:

Figure 87: License/Certification Information

6. Enter the provider's Malpractice Insurance Carrier Information, and upload or fax a copy of his/her current malpractice insurance face sheet. Click **Save & Next** to continue.

6. MALPRACTICE INSURANCE


A. MALPRACTICE INSURANCE
List below your **current** malpractice carrier. Upload a copy of your current policy certificate and/or declarations page indicating you as the covered clinician, and showing the coverage limits and dates of coverage. If you are unable to upload this document, please fax to 1-866-612-7795.



Upload Certificate

If you have not possessed coverage with the same carrier for the past 5 years, list below the name and complete address of any other malpractice carrier who has provided coverage for you for the most recent five (5) year period. **If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.**

[Edit Carrier Policy Effective Expired Limits Delete](#)
No Records Found




Add Insurance Carrier

Please provide information on pending and/or settled malpractice claims.

B. MALPRACTICE CLAIMS
Be as specific as possible with regard to procedures, names, dates, and actions. Explanations provided on pending and/or settled malpractice claims must include the minimum information requested below.


No claims are currently attached to this provider



Add Claim

Use the Add Claim button to document any additional occurrences and additional claims.

C. MALPRACTICE DOCUMENTS
Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudications, original complaint and final disposition). The documentation must be from an attorney or the entity that issued the judgment. If you are unable to upload this document, please fax to 1-866-612-7795.





Upload Malpractice Document

Figure 88: Malpractice Insurance Information

7. Enter the provider's Work History Information. Click **Save & Next** to continue.

7. WORK HISTORY

This section may be used to provide your work history. A current Curriculum Vitae (**must specify month and year**) may be submitted in lieu of completing this section by clicking on the "Upload CV" button. Otherwise, please use the "Work History" button to manually input your information. If a lapse of employment has happened since earning a graduate degree, please upload a document that explains the reasons why the lapse occurred. If you are unable to upload this document, please fax to 1-866-612-7795.

[Edit From\(MM/YYYY\) To\(MM/YYYY\) Description of Activities Delete](#)
 No Records Found




Figure 89: Work History Information

8. If applicable, enter the EAP Counselor Information. Click **Save & Next** to continue.

8. EAP COUNSELOR ONLY

If you are not currently enrolled as an EAP provider and are interested in participating, please contact the Provider Services Line at 1-800-397-1630.

Are you interested in participating in the EAP specialty network? *

☐ Yes ☐ No

If yes, go on.

Do you meet the minimum VO criteria for your licensure level AND the criteria for the specialty EAP network?

☐ Yes ☐ No

If yes, complete the following for the EAP specialty network in its entirety.

A. KNOWLEDGE/WORK EXPERIENCE OF EAP CORE TECHNOLOGY BY:

☐ Active status as a Certified Employee Assistance Professional (CEAP); **or**
☐ Two (2) years of verifiable experience as an internal EAP Counselor, and/or as external EAP Consultant to other organizations.

On the grid below, please fill in the column "Type" with one of the following numbered options:

Type 1: Management and/or union representative consultation on impact of personal problems on performance issues, appropriate use of constructive confrontation and role of EAP.


Type 2: Direct care function of EAP practice including assessment/referral, short-term counseling and linkages to treatment and/or community resources.

Type 3: Crisis Intervention including critical incident stress management (CISM) services.

Type 4: Training and experience in organizational dynamics/development, human resource management or industrial social work/ psychology.

Type 5: Assessment and identification of drug alcohol abuse/dependency problems and appropriate treatment interventions.

[Edit Type From\(MM/YYYY\) To\(MM/YYYY\) Title Employer Employer Address Delete](#)
 No Records Found




B. KNOWLEDGE/WORK EXPERIENCE IN ASSESSMENT/TREATMENT OF SUBSTANCE ABUSE

Yes N/A

☐ ☐ Active status as a Certified Employee Assistance Professional (CEAP) with an acceptable level of experience in the assessment and/or treatment of chemical dependency; **and/or**
☐ ☐ Possess one (1) year experience in a substance abuse treatment facility; **and/or**
☐ ☐ Completed a state-level certification acceptable to support eligibility for the National Certified Addiction Counselor (NCAC) credential; **and/or**
☐ ☐ Possess International Certified Alcohol and Drug Counselor Certification (ICADC); **and/or**
☐ ☐ Possess a minimum of six (6) units of continuing education (CEU's, PDH's) in chemical dependency assessment/treatment; **and/or**
☐ ☐ Completed three (3) graduate level hours of coursework in chemical dependency. (**Attach copies of the certificates.**)

[Edit Certification Type Certificate # Expiration Date Delete](#)
 No Records Found



Indicate one (1) year of experience in a substance abuse treatment facility below: **If you meet this criteria, please complete the following work history section even if this information is contained on your resume!**

[Edit From\(MM/YYYY\) To\(MM/YYYY\) # Hours/Week Title Employer Description of Position Delete](#)
 No Records Found



Figure 90: EAP Counselor Only

9. If applicable, enter the necessary Disability Provider Network Information. Click **Save & Next** to continue.

9. DISABILITY PROVIDER NETWORK ONLY

Please note that ValueOptions® is not currently credentialing new practitioners for this network. If completed, your responses will be used for informational purposes only.

Are you interested in participating in the Disability Provider Network specialty network? ☒ Yes ☐ No

If yes, go on.

Do you meet the minimum VO criteria for your licensure level AND the criteria for the Disability Provider Network specialty network? ☐ Yes ☐ No

If yes, complete the following for the Disability Provider Network specialty network in its entirety.

A. Disability Assessment Specialists - Psychiatrists and Psychologists Only

1. Indicate how many years of experience you have assessing patients with psychiatric disabilities
☐ 2-4 ☐ 5-7 ☐ 8-10 ☐ 11-13 ☐ more than 13

2. Indicate how many patients you have evaluated in which psychiatric disability was an issue
☐ 0-10 ☐ 11-20 ☐ 21-35 ☐ 36-50 ☐ more than 50

3. Indicate in the table below by checking the appropriate box the number of each type of disability related evaluations you have done in the past 2 years

	<=10	11-30	31-50	51-70	>71
Primary Psychiatric	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Secondary psychiatric where medical disability was primary	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forensic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worker's Compensation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Will you routinely be able to accept referrals from ValueOptions® Disability Care Managers within 24 hours? ☐ Yes ☐ No

5. Will you routinely be able to conduct face-to-face disability evaluations of ValueOptions® referred patients within 72 hours of referral? ☐ Yes ☐ No

6. If you are a psychologist, do you administer, score and interpret psychological tests as part of your assessment process? ☐ Yes ☐ No

7. Certification

a. Is QME (Qualified Medical Examiner) certification available in the state where you practice? ☐ Yes ☐ No ☐ N/A

b. Do you have QME certification? ☐ Yes ☐ No ☐ N/A

c. Are you certified by the American Board of Independent Medical Examiners? ☐ Yes ☐ No ☐ N/A

d. Are you eligible for certification by the American Board of Independent Medical Examiners? ☐ Yes ☐ No ☐ N/A

e. Are you a member of the American Academy of Psychiatry and the Law? ☐ Yes ☐ No ☐ N/A

f. Are you a member of the American Board of Forensic Psychology? ☐ Yes ☐ No ☐ N/A

B. Disability Treatment Specialists - All Disciplines

1. Indicate how many years of experience you have treating patients with disabilities
☐ 2-4 ☐ 5-7 ☐ 8-10 ☐ 11-13 ☐ more than 13

2. In the past 2 years, indicate how many patients you have treated in which disability was an issue
☐ 0-10 ☐ 11-20 ☐ 21-35 ☐ 36-50 ☐ more than 50

C. All Disability Network Applicants (continued) - Assessment and/or Treatment Specialists

1. What is your primary focus when developing a treatment plan for disability cases? (Check all that apply)

<input type="checkbox"/> Impact of impairment on job functions	<input type="checkbox"/> Type of treatment
<input type="checkbox"/> Workplace issues	<input type="checkbox"/> Psychosocial/medical issues

2. Are you willing to make collateral contacts with employers, family members, other providers, etc.? ☐ Yes ☐ No

3. Indicate the settings where you have experience with disability cases and the number of cases you served in that setting in the past two (2) years.

<input type="checkbox"/> Inpatient hospital	Number of cases: <input type="text"/>	<input type="checkbox"/> Rehabilitation center	Number of cases: <input type="text"/>
<input type="checkbox"/> Intensive outpatient program	Number of cases: <input type="text"/>	<input type="checkbox"/> Workplace	Number of cases: <input type="text"/>
<input type="checkbox"/> Outpatient	Number of cases: <input type="text"/>		

4. Are you willing and able to communicate with a ValueOptions® Disability Care Manager on an ongoing and consistent basis? ☐ Yes ☐ No

Figure 91: Disability Provider Network Only Information

10. If applicable, enter the Fitness for Duty Assessment Specialist Network Information (FFD Specialist). Click **Save & Next** to continue.

10. FITNESS FOR DUTY ASSESSMENT SPECIALIST NETWORK ONLY

Please note that ValueOptions® is not currently credentialing new practitioners for this network. If completed, your responses will be used for informational purposes only.

Does this apply?* ☒ Yes ☐ No

Are you interested in participating in the Fitness for Duty specialty network? ☐ Yes ☐ No

If yes, go on.
Do you meet the minimum VO criteria for your licensure level AND the criteria for the specialty FFD network? ☐ Yes ☐ No

If yes, complete the following for the Fitness for Duty specialty network in its entirety.

Check the box for the discipline that applies to you and answer the questions for that discipline.

A. ☐ Psychiatrist or Addictionist

- Are you a member of the American Academy of Psychiatry and the Law? ☐ Yes ☐ No
- Do you hold current and valid ASAM certification? ☐ Yes ☐ No
- Do you have at least 2 years of experience engaged in Fitness for Duty (FFD) evaluations? ☐ Yes ☐ No
- Have you evaluated clinical cases where fitness for duty and/or substance abuse was the primary issue? ☐ Yes ☐ No

B. ☐ Psychologist

- Do you hold ABBP certification? ☐ Yes ☐ No
- Do you have at least 2 years of experience engaged in Fitness for Duty (FFD) evaluations? ☐ Yes ☐ No
- Have you evaluated clinical cases where fitness for duty and/or substance abuse was the primary issue? ☐ Yes ☐ No

C. All Fitness for Duty Assessment Specialist applicants complete the following:

- Are you willing to function as part of an FFD team assigned to one or more specific locations? ☐ Yes ☐ No ☐ N/A
- Are you able to schedule and perform a face-to-face FFD evaluation within 24 hours if requested, provide feedback immediately after the evaluation if requested (with the exception of psychological testing results), and complete and return an FFD form to ValueOptions® within 3 business days? ☐ Yes ☐ No ☐ N/A
- Are you willing to engage in on-going dialogue with ValueOptions® care managers on an as-needed basis? ☐ Yes ☐ No ☐ N/A
- Are you willing to testify in legal/court proceedings when requested? ☐ Yes ☐ No ☐ N/A
- Have you performed at least 25 evaluations where substance abuse and/or FFD was an issue during the last 2 years? ☐ Yes ☐ No ☐ N/A
- Are you familiar with alcohol and drug testing policies and procedures? ☐ Yes ☐ No ☐ N/A
- Are you familiar with workplace issues? ☐ Yes ☐ No ☐ N/A
- Do you have experience working with and evaluating employees who are in federally regulated safety sensitive jobs? ☐ Yes ☐ No ☐ N/A
- If you are a psychologist have you utilized psychological tests as part of your FFD evaluation process? ☐ Yes ☐ No ☐ N/A
- If you perform psychological testing are you able to schedule it within 72 hours of a request, and send a completed written report to ValueOptions® within 3 business days after completion of the testing? ☐ Yes ☐ No ☐ N/A
- Are you eligible or do you hold NCAC, ICADC or state-level addictions treatment certification/licensure? ☐ Yes ☐ No ☐ N/A
- Are you willing to allow ValueOptions® to request a criminal background check on you? ☐ Yes ☐ No ☐ N/A

D. Indicate in the grid below your level of experience (number of cases) with each of the issues identified:

Trigger for a Fitness for Duty Evaluation	Number of cases seen where this was the primary cause for evaluation	
	...In the last 2 years	...In my career
Positive test on a random drug/alcohol screen	<input type="text"/>	<input type="text"/>
Positive drug/alcohol test result where test was administered for reasonable cause	<input type="text"/>	<input type="text"/>
Unusual/aberrant/bizarre behavior in the workplace	<input type="text"/>	<input type="text"/>
Return to work post-critical incident	<input type="text"/>	<input type="text"/>
Sub-standard work performance	<input type="text"/>	<input type="text"/>
Absenteeism	<input type="text"/>	<input type="text"/>
Pre-employment screening	<input type="text"/>	<input type="text"/>
Change in job responsibilities to a level involving potential for increased safety hazard(s)	<input type="text"/>	<input type="text"/>
Column Totals	<input type="text"/>	<input type="text"/>

E. Check the settings in which you have performed Fitness for Duty evaluations:

☐ Industry
 ☐ Fire, Police, Safety

☐ Military
 ☐ Oil, Mineral, Forestry

☐ Health Care
 ☐ Utilities (Water, Gas, Electric, etc.)

☐ Other (specify):

Figure 92: FFD Specialist Information

11. Answer all the Provider Profile Information. If the **Yes** option button is selected, please provide an explanation in the Comments section at the bottom of the page. Click **Save & Next** to continue.

11. PROVIDER PROFILE

A. Please answer all provider profile questions.

NOTE: If "yes" is checked, please explain fully in the space provided.

	Yes	No	N/A
1. Health Status: Do you have any physical, mental, or emotional condition, including but not limited to any history of drug or alcohol abuse, which currently impairs your ability to render the professional services which are the subject of this application? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to safely and competently render the professional services, which are the subject of this application.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Insurance Coverage: Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. License: Has your medical or professional license in any state ever been revoked, suspended, placed on probation, conditional status, or limited?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
a. Have you ever voluntarily surrendered your license?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Are formal charges pending against you at this time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. DEA: Has your DEA Registration Certificate ever been suspended, revoked, subjected to probation, placed on conditional status, or limited?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Hospital Privileges or Participation Status: Has any hospital ever dismissed you from its staff?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
a. Has any hospital ever refused or denied you privileges or any health plan or other provider network entity refused or denied you participation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Have you ever voluntarily surrendered your hospital privileges?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Have you voluntarily ended your participation status with a health plan or other provider network entity while under investigation or in lieu of investigation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Has any hospital ever limited, suspended, revoked or terminated your staff privileges or otherwise dismissed you from its staff?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Has any health plan or provider network entity ever limited, suspended, revoked or terminated your participation status?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Hospital or Provider Network Sanctions: Have you ever surrendered your hospital clinical privileges or health plan/provider network participation due to possible censure, restriction, suspension, revocation or termination of such privileges and/or provider network participation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Professional Membership(s): Has your membership in any professional society or association ever been canceled, revoked, or censured?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Criminal Offenses: Have you ever been arrested, charged with or convicted of a felony or involved in charges relating to moral or ethical turpitude, including crimes with children?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
a. Have you ever been named as a defendant in any criminal proceeding?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Board Discipline: Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county, state or national professional society; hospital medical or clinical staff)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Malpractice Action: Has any malpractice action against you been brought or settled in the past 5 years or has there been any unfavorable judgment(s) against you in a malpractice action?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
a. To your knowledge, is any malpractice action against you currently pending?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. If your answer to question 10 above is yes, please mark the number of malpractice claims pending and/or closed: <div style="display: flex; align-items: center;"> <input type="radio"/> One <input type="radio"/> Two <input type="radio"/> More than 2 (please give number) <input style="width: 50px; border: 1px solid black;" type="text"/> </div>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Have you ever been a defendant in any lawsuit involving your practice where there has been an award or payment of \$100,000 or more?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Have you had any malpractice claims where there has been an award or payment of \$100,000 or more?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Medicare/Medicaid: Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by any Medicare, Medicaid or TRICARE program?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Medicare Participation: Are you a Medicare participating provider? (Note: N/A=not eligible)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
a. If you answered yes above, you have completed or will complete the required annual trainings for Medicare, including Fraud, Waste and Abuse training, and agree to provide verification if requested. (Note: if NO is checked, please explain fully)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. State Medical Assistance/Medicaid Program Participation: Are you a participating provider in the State Medical Assistance Program(s) where you practice (i.e., Medicaid, Medi-Cal, MaineCare)? (Note: N/A = not eligible)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Comments: If you answered yes to questions 1-11 or no to question 12.a, please explain fully in this space.	<div style="border: 1px solid black; height: 100px; width: 100%;"></div>		

Figure 93: Provider Profile Information

12. Enter the necessary information for the Substitute for Form W-9 Request for Taxpayer Identification Number. Click **Save & Next** to continue.

12. Substitute for Form W-9 Request for Taxpayer Identification Number

Pursuant to Internal Revenue Service Regulations, you must furnish your Taxpayer Identification Number (TIN) to ValueOptions®. If this number is not provided, you may be subject to a 31% withholding on each payment. To avoid this 31% withholding and to insure that accurate tax information is reported to the Internal Revenue Service, please use this form to provide the requested information.

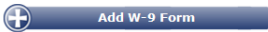
If you are an **individual**, you must furnish your individual name as shown on your social security card. If you have changed your last name, for instance, due to marriage, without informing the Social Security Administration of the name change, and you are billing using your Social Security number, please enter your first name, the last name shown on your Social Security card, and your new last name.

If you are a **sole proprietor**, you must furnish your individual name as shown on your Social Security card, and either your SSN or EIN (Employer Identification Number). You may also enter your business name or "doing business as" name on the business name line.

Please use the **Add W-9 Form** button to enter the required information.

Substitute for Form W-9

No records are currently attached to this provider




The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signature

OR

Name of the person completing the form

Date:  (MM/DD/YYYY)


Date:  (MM/DD/YYYY)


Figure 94: W-9

13. Follow the directions on this page to complete and upload any additional contract-specific Supporting Documentation as necessary. Click **Save & Next** to continue.


Note: Customized text along with a link can be added to this tab as necessary.

13. SUPPORTING DOCUMENTATION

Specific contracts may require additional documentation to complete the recredentialing process. Please go to our website and check the Credentialing Supporting Documents section on the Administrative Forms page via the below link to access any applicable contract specific documents to print, complete and then upload to this page to submit. If you are unable to upload the necessary document(s), please fax to 1-866-612-7795.

Important Note for Florida Medicaid Practitioners: Please submit the following form. 

[Florida Medicaid Disclosure of Ownership and Control Form](#)

Important Note for California Practitioners: If you identified any foreign languages that you use fluently in treating patients, you will need to complete and submit the ValueOptions of California Language Capability Attestation available via the link below. 

[ValueOptions® of California, Inc. Language Capability Attestation](#)



Open	Name	Date/Time Uploaded	Delete
<div style="display: flex; justify-content: space-around;">   </div>			

Figure 95: Supporting Documentation

14. Read the Attestation/Participation Statement. If manually signing and faxing the Attestation form, follow the instructions on this page. (After indicating their intention to fax the form, users should print the document *prior to saving*.)

14. ATTESTATION/PARTICIPATION STATEMENT

For purposes of making this application for participation in the ValueOptions®, Inc. provider network, I certify that all information provided to ValueOptions® is true and correct to the best of my knowledge and belief. I agree to notify ValueOptions® promptly if there are any material changes in the information provided, whether prior to or after my acceptance as a ValueOptions® participating provider. I understand and agree that if ValueOptions® discovers that my application contains any significant misstatement, misrepresentations, or omissions, ValueOptions® may void, in its sole discretion, this application and any related participating provider agreements.

I authorize ValueOptions® and its Credentialing Verification Organization (CVO) to consult with the National Practitioner Data Bank, and associated Data Banks, State Licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Education Commission for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character, moral and ethical qualifications. I also authorize all of them to release such information to ValueOptions®. I release ValueOptions® and its CVO and employees and agents and all those whom ValueOptions® and its contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluation my application.

I understand that ValueOptions® may be required by the Federal government or its clients to perform a criminal records check as a condition for participation and that ValueOptions® has the right to obtain a copy of a criminal history report and share such record with the account for which member are treated. I also understand that I have the right to challenge the accuracy and completeness of any information contained in such a report.

I consent to the release by any person to ValueOptions® and its CVO, all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualifications, including information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

I further understand and agree that: (a) I am responsible for producing all information required or requested by ValueOptions® in connection with this application; (b) ValueOptions® shall not complete the processing of this application until such information is provided by me. In the event that ValueOptions® decides not to accept me as a participating provider and I desire to have the decision reviewed, I will appeal such determination to the ValueOptions® Provider Appeals Committee ("PAC"). By signing this Attestation/Participation Statement I am not precluded from pursuit of any separate rights that I may have under state or federal laws.

→

[Click here to sign this document electronically](#)

OR

→
☐ Check here if you intend to fax the Attestation form

Faxing Instructions

→ **PRINT ([Click Here](#)) AND FAX SIGNED ATTESTATION WITHIN 5 DAYS TO:**

ValueOptions, Inc.
National Network Operations
FAX: 1-866-612-7795

If you have any questions regarding the application, please call 1-800-397-1630

ValueOptions®, Inc. is an equal opportunity organization, which does not discriminate on the basis of race, color, sex, national origin, religion, age, disability, or veteran status in admission or access to or treatment or employment in its programs and activities. Applicants who may have inquiries regarding our policy and procedures should contact the National Network Development and Management Department.

Save

Figure 96: Attestation Information

Electronically Sign the Attestation

To electronically sign the form, do the following:

1. Click in the highlighted **Click here to sign this document electronically** area on the Attestation page. The Welcome to the Provider Esignature Process page displays.
2. Review the steps on the Welcome to the Provider Esignature Process page to apply an electronic signature.
3. Click on [Proceed to ESIGN Disclosure](#).

The US Federal Consumer Disclosure – E-Sign Act page displays.

4. Carefully read the information on the this page.
5. Click on [Yes](#) to signify consent to complete and sign the document electronically. The Signature Information page displays.
6. Enter the user's name to apply to the attestation document on the Signature Information page.

Note: Enter the name as you would normally write it when signing a paper document, using upper and lower case letters as appropriate.

7. Click the **Submit** button to display the Attestation/Participation Statement that the user is being asked to electronically sign.
8. Click in the highlighted **Click Here to Sign** area to electronically sign the document. A Thank You page displays stating that the document has been successfully signed.
9. Follow the instructions on the Thank You page to download a copy of the document and save it to your computer.

After the user saves the signed attestation locally or closes the Esign confirmation window, a pop-up window displays indicating that the form has been submitted to Beacon Health Options. At that point, if any of the required tabs were left blank, a pop-up window displays informing the user to enter information for the missing tabs. The completed PDS application is automatically submitted once the user has applied his or her Esignature.

Following is an example of the pop-up window that displays when a practitioner has submitted his or her PDS application.



Figure 97: Practitioner Final Submission Pop-up

There are also options on the PDS to **Print current page**, **Print all pages**, or **Close**.

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Facility Data Sheet

The Facility Data Sheet (FDS) is Beacon's online facilities and organizational provider re-credentialing application and is similar to the Provider Data Sheet (PDS). Like the PDS, it is accessible only at the time re-credentialing is needed. Facilities are notified via telephone, fax, e-mail, or mail when re-credentialing is due and the FDS is available.

Click on [Provider Data Sheet](#) to access the FDS. The FDS contains the following tabs.

- General Information
- License/Accreditation
- Insurance
- Demographic
- Service Locations & Programs
- Addenda
- Supporting Documentation
- Roster of Providers
- Participation Statement

1. Review the General Information, and make any necessary corrections or additions. Click **Save & Next** to continue.

Note: A red asterisk (*) indicates a required field.

1. GENERAL INFORMATION

A. Facility/Program Information

Facility Name*	ALEXANDRIA HOSPITAL			DBA/Trade Name*		NPI#	
Mailing Address Line 1*	4320 SEMINARY RD			Mailing Address Line 2			
City*	ALEXANDRIA	State*	VA	Zip*	22304-1535		
Phone:(include area code)*	703-504-3000	Ext		TIN*		Fax:(include area code)	
Email address:*							

Note: ValueOptions® credentials and contracts facilities based on single Tax Identification Numbers (TINs). This recredentialing application applies to the above TIN only.

B. Facility/Program Points of Contact

Chief Executive Officer:		Phone:		Ext:	
Managed Care Director:		Phone:		Ext:	
Person completing this application:		Phone:		Ext:	
		Fax:			
		Email address:			
Billing/Claims Contact Person:		Phone:		Ext:	
Contracting Contact Person /Title:		Phone:		Ext:	
		Fax:			
		Email address:			
Chief Medical Officer:		Phone:		Ext:	
Chief Clinical Officer/Manager:		Phone:		Ext:	
Business Manager:		Phone:		Ext:	
Information Systems Manager:		Phone:		Ext:	
President of the Board of Directors:		Phone:		Ext:	
Chief Financial Officer:		Phone:		Ext:	
Website Address of Facility					

C. Corporate Health System (Please complete if Facility/Program is part of a corporate health system).

Corporate Name

Contact Name Title

Mailing Address Line 1 Mailing Address Line 2

City County State Zip

Phone:(include area code) Ext Fax:(include area code)

Email address:

D. Facility Description.

GENERAL HOSPITAL

E. Business Classification

Ownership: ☐ Private ☐ Public ☐ Government Program (State Operated/Federal/State/County/City)

Status: ☐ For-Profit ☐ Not-for-Profit

Pennsylvania Medicaid Providers only: ☐ Single County Authority ☐ Base Service Unit ☐ Not Applicable

Colorado Medicaid Providers only: ☐ Rural Health Center ☐ Federally Qualified Health Center

Figure 98: General Information

2. Enter the facility's License/Accreditation Information, and upload or fax a copy of their current certificate(s). Click **Save & Next** to continue.


2. LICENSE/ACCREDITATION INFORMATION

F. License/Accreditation
 Please check all that apply to your Facility and upload or submit copies of all accreditation certificates via fax:


Has the Facility been reviewed and accredited by JCAHO?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
Has the Facility been reviewed and accredited by CARF?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
Has the Facility been accredited by AOA?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
Has the Facility been accredited by COA?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
Has the Facility been accredited by CHAP?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
Has the Facility been accredited by AAAHC?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
Has the Facility been accredited by NCQA?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
Has the Facility been accredited by DNV/NIAHO?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
Please indicate any other accreditation/certificates <input style="width: 100%;" type="text"/>	

NOTE: If your organization is not accredited by one of the accrediting bodies listed above, a site review of your Facility/Program will need to be conducted based upon the need for providers in your area. A site survey preparation document will be sent to you in advance of the site survey, which will be scheduled at a mutually agreed upon date. A copy of a CMS certification letter or on site survey results performed by the State may be accepted in lieu of an onsite review by ValueOptions[®]. Please provide this information with your application if applicable.


Has the Facility been certified by Medicare?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
If Yes, Please enter the Medicare # <input style="width: 100%;" type="text"/>	
Has the Facility been certified by Medicaid?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
If Yes, Please enter the Medicaid # <input style="width: 100%;" type="text"/>	
Does the Facility presently receive DMHAS Grant Funds?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
If Grant Funds are received, please explain <input style="width: 100%;" type="text"/>	



G. State License(s)
 Please add information for all applicable licenses and upload or submit copies via fax.

Edit	Type	Number	Certifying Entity	State	Status	Renewal	Expiration
<div style="display: flex; align-items: center;">  </div>							

For Each licence/certification you hold, you will need to click the Add License/Certification button to input your information.



NOTE: If you are unable to upload applicable license/accreditation certificates, please submit via Fax to 1-866-612-7795.


Figure 99: License/Accreditation Information

3. Enter the facility's Malpractice Insurance Carrier Information, and upload or fax a copy of their current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates. Click **Save & Next** to continue.

3. INSURANCE


H. Liability Insurance Information

List below your current malpractice carrier. Upload a copy of your current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates that identify the limits of liability of \$1million/\$3million and the policy period. Documents must show "Professional Liability". If you are unable to upload this document, please fax to 1-866-612-7795.



If you have not possessed coverage with the same carrier for the past 5 years, list below the name and complete address of any other malpractice carrier who has provided coverage for your facility for the most recent five(5) year period. **if there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.**

Edit	Carrier	Policy	Effective	Expired	Limits	Delete
Total:0						



Does Facility carry general liability insurance? ☐ Yes ☐ No

I. Malpractice Claims Information/Provider Profile

Please answer the following questions regarding the Facility's Behavioral Health Program(s).

1. Has the Facility/Program had professional liability insurance refused, revoked, declined or accepted on special terms in the past five years? ☐ Yes ☐ No
2. Has any government agency suspended, revoked, or taken other actions against the Facility/Program's license to conduct business in the past five years?(To include Medicaid / Medicare) ☐ Yes ☐ No
3. Have any memberships in professional organizations and/or accreditations been revoked, reduced, denied, or suspended by others or voluntarily given up by the Facility/Program in the last five years, or are any actions now under way which may lead to sanctions? ☐ Yes ☐ No
4. Have any owners, officers, or shareholders of the Facility/Program been convicted of a crime, excluding misdemeanors, in the past five years? ☐ Yes ☐ No
5. Has the Facility had any adverse incidents involving any ValueOptions® Members in the past five years? ☐ Yes ☐ No
6. Has the Facility?Program had any settled claims or judgments relating to sexual misconduct or civil rights violations in the past five years? ☐ Yes ☐ No

Number of claims (check one): ☐ 0 ☐ 1 ☐ 2 ☐ More


7. Has the facility/program been a defendant in five(5) or more lawsuits within the past five (5) years involving any ValueOptions® Members or any lawsuits involving ValueOptions® Members in the past five(5) years where there has been awards or payments of \$250,000.00(two hundred and fifty thousand dollars) or more? If YES, Please enter the total number:

PLEASE COMPLETE THE MALPRACTICE CLAIM INFORMATION WORKSHEET BELOW IF QUESTIONS 5,6 OR 7 WERE ANSWERED "YES"

8. Does the facility/program comply with §1128 of the Social Security Act by not hiring, continuing to employ, or contracting with individuals listed on the Office of Inspector General's List of Excluded Individuals/Entities(to include owners, officers, employees, subcontractors, and others identified in § 1128)? ☐ Yes ☐ No

J. Malpractice Claim Information WorkSheet

Please provide information on what the organization's response was to the allegations and what steps were taken to prevent any future incidents for each claim listed.

Edit	Occurrence	Insurance Company	Hospital	Delete
<div>  </div> <p>Use the Add Claim button to document any additional occurrences and additional claims.</p>				

K. Malpractice Documents

Documentation is required if you have malpractice claims pending or settled in the past five(5) years(include any settle ments/adjudications, original complaint and final disposition). The documentation must be from an attorney or the entity that issued the judgment. If you are unable to upload this document , please fax to 1-866-612-7795.




Figure 100: Insurance Information

4. Enter the facility's Demographic Data, and upload or fax a copy of their current 8(a) and HUBZone certificate(s) if applicable. Click **Save & Next** to continue.

4. DEMOGRAPHIC

K. DEMOGRAPHIC DATA:

ValueOptions®, Inc., is contracted with various public agencies at the Federal, State and Local levels. Some of these contracts require us to verify the business size of our Network providers/facilities as well as their socioeconomic status. The collection of this data will not be used for credentialing purposes. This information will be used in aggregate to supply data to the Federal or State government as part of a government contracting process. **These questions should be answered considering the Facility TIN in which claims are filed.** In order to assist us in facilitating this process, we ask you complete the questions below for the TIN in which you claims are filed.

What is the North American Industrial Classification System Code (NAICS) for this business?

If not listed in drop-down selection list above, please enter the NAICS that matches your companies concern here:

Other (specify):

Click here for some of the common NAICS codes for providers of healthcare services with their applicable average annual size standard. If your business type is not listed below, contact the Small Business Administration in your area for assistance or for a complete listing of all NAICS codes, please visit <http://www.sba.gov/size>.

This information is for demographic reporting purposes only and will not be used for credentialing. This information may be used in the aggregate to supply data to the federal or state government as part of a government contracting process. **The information will be disclosed only for the purposes stated.** If this information is applicable to your business, please answer the following questions.

Are you an employee of a professional or other corporation? ☐ Yes ☐ No

Is this business considered a small business as defined by the Small Business Administration? ☐ Yes ☐ No

• **Small Business** means a concern that is independently owned and operated, not dominant in the field of operation in which it is operating under Contracts and meets size standards set by the Small Business Administration (SBA). Small Business size varies by NAICS, see chart above. The number of employees or annual gross revenue indicates the maximum allowed for a concern to be considered a small business. Small Business size examples: A business is considered small business if its annual gross revenues (an average for the last three years) are less than the amount specified for its NAICS number (see above section for examples).

Is this business considered a Women-Owned Small Business? ☐ Yes ☐ No


• **Woman Owned Small Business** means a concern that is at least 51 percent owned by one or more women and whose management and daily business operations are controlled by one or more women and meets size standards to be considered small (see above).

Is this business considered a Small Disadvantaged Business? ☐ Yes ☐ No

• **Small Disadvantaged Business** means a concern that is at least 51 percent owned by a disadvantaged person(s) and that person(s) provides daily management and control of the firm. The following are considered disadvantaged groups (all must be U.S. citizens): Black Americans; Hispanic Americans; Native Americans (American Indians, Eskimos, Aleuts, and Native Hawaiians); Asian Pacific Americans (persons with origins from Japan, China, the Philippines, Vietnam, Korea, Samoa, Guam, U.S. Trust Territory of the Pacific Islands [Republic of Palau], Commonwealth of the Northern Mariana Islands, Laos, Cambodia [Kampuchea], Taiwan, Burma, Thailand, Malaysia, Indonesia, Singapore, Brunei, Republic of the Marshall Islands, Federated States of Micronesia, Macao, Hong Kong, Fiji, Tonga, Kiribati, Tuvalu, or Nauru; Subcontinent Asian Americans (persons with origins from India, Pakistan, Bangladesh, Sri Lanka, Bhutan, the Maldives Islands or Nepal), and Members of other groups designated by the SBA. Individual/concern other than one of the proceeding, currently certified for participation in the Minority Small Business and Capital Ownership Development Program under section 8 (a) of the Small Business Act.

Is this business considered 8(a) certified? If yes, please include copy of certification. ☐ Yes ☐ No

• **8(a) Certified** means a concern that has received a certification for this Program from the Small Business Administration.

 **Upload 8(a) Certificate**

Is this business considered a Veteran-Owned Small Business? ☐ Yes ☐ No


• **Veteran Owned Small Business** means a concern that is at least 51 percent owned by one or more veterans and whose management and daily business operations are controlled by one or more veterans and meets size standards to be considered small (see above).

Is this business considered a Service Disabled Veteran-Owned Small Business? ☐ Yes ☐ No

• **Service-Disabled Veteran-Owned Small Business** means a concern owned and controlled by a service disabled veteran. The term "service-disabled veteran" means a veteran with a disability that is service connected (as defined in section 101 (16) of title 38, United States Code) and meets size standards to be considered small.

Is this business considered a HUBZone Small Business? If yes, please include copy of certification. ☐ Yes ☐ No

• **HUBZone Small Business** A firm can be found to be a qualified HUBZone concern, if it is small; it is located in an "historically underutilized business zone" (HUBZone); it is owned by one or more U.S. Citizens; at least 35 percent of its employees reside in a HUBZone. Must be certified by the U.S. Small Business Administration (SBA). SBA in your area can help to determine if you're located in a HUBZone and help you receive certification. Copy of the certification needs to be submitted with your credentialing application.

 **Upload HUBZone Certificate**

Is this business considered a large business as defined by the Small Business Administration? ☐ Yes ☐ No

• **Large Business** means a concern that does not qualify for a small business as defined above.

Is this business considered a Historically Black College/Minority Institution? ☐ Yes ☐ No

• **Historically Black College** means institutions determined by the Secretary of Education to meet the requirements of 34 CFR 608.2. The term also means any nonprofit research institution that was an integral part of such college or university before November 14, 1996. Minority Institution means institution of higher education meeting the requirements of section 1046(3) of the Higher Education Act of 1965 (20 USC 1135d-5 (3)); Enrollment of a single minority or a combination of minorities exceeds 50 percent of the total enrollment. The term also includes Hispanic serving institutions as defined in section 316(6) (1) of such Act (20 USC 1059c(b)).

If your business could be classified as a minority-owned business, which of the following categories would it fall under?
This question is optional.

☐ **Caucasian**

☐ **Hispanic (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)**

☐ **Black (African, Jamaican or West Indian descent)**

☐ **Native American or Alaskan Native (Persons having origins in any of the original peoples of America)**

☐ **Asian or Pacific Islander (persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent or the Pacific Islands)**

Figure 101: Demographic Data

- The Service Locations & Programs page lists all the service locations that were active at the time the data sheet was created. (That is, the data sheet is a “snapshot” of the service locations that were active on the day the data sheet was created.) When the page is first accessed the service location headings display in **red**, indicating that the user needs to take action. The user must verify each service location as well as the programs for each location in order to submit the application.

5. SERVICE LOCATIONS & PROGRAMS

To verify your Service Locations & Programs, select the Verify icon in the middle of the Service Location listing. In order to submit this application online you must verify each Service Location and its related Programs. If you need to make additional changes after you have already verified a Service Location, click the verified banner to expand the section and then click the Edit icon.

SERVICE LOCATION INFORMATION

INOVA HEALTH SYSTEM SERVICE LOCATION —ACTION REQUESTED

Name: INOVA HEALTH SYSTEM Contact: Phone: Medicare: 540505861
Address: PO BOX 37022 Fax: Medicaid: Tax Id:
BALTIMORE, MD 21297-3022

Billing Information
Name: INOVA HEALTH SYSTEM Phone: BALTIMORE Tax Id: 540505861
Address: PO BOX 37022, City: State: MD
Zip: 21297-3022

Primary: N Handicap Accessible: U Public Transportation: U




INOVA HEALTH SYSTEM SERVICE LOCATION —ACTION REQUESTED

Name: INOVA HEALTH SYSTEM Contact: Phone: Medicare: Medicaid: Tax Id:
Address: 4320 SEMINARY RD Fax: Tax Id:
ALEXANDRIA, VA 22304-1592

Billing Information
Name: INOVA HEALTH SYSTEM Phone: BALTIMORE Tax Id: 540505861
Address: PO BOX 37022, City: State: MD
Zip: 21297-3022

Primary: Y Handicap Accessible: Y Public Transportation: Y

Figure 102: Service Locations and Programs

- Click anywhere in the heading to collapse/expand a specific service location.
- Click the  icon to delete a specific service location. (If a service location is deleted in error, click the  icon to undo the deletion.)
- Click the  icon to verify a specific service location. The following pop-up window displays.

Practice Location Information

Please review the Service Location information below. If you are unable to complete your review of this location but want to save your updates, select the Save button. To continue making updates at a later time, select the Edit icon on the corresponding Service Location on Tab 5. Service Locations & Programs. Alternatively, if you have completed your review of this location click the Verify & Next button to review this location's Programs.

Check here if this location should be removed from our records (Location no longer valid) ☐

Practice Name: * INOVA HEALTH SYSTEM

Address: PO BOX 37022

Address Line 2:

City: BALTIMORE

County: BALTIMORE CITY

State: MD Zip: 21297-3022

Office Manager (if applicable):

Telephone: Ext:

Fax: Ext:

Tax ID: 540505861

Medicare Number:

Medicaid Number:

Billing Location Information

Is Billing Information same as Practice? ☒

Billing Location Name: * INOVA HEALTH SYSTEM

Address: PO BOX 37022

Address Line 2:

City: BALTIMORE

County: BALTIMORE CITY

State: MD Zip: 21297-3022

Telephone: Ext:

Tax ID: 540505861

Is this the primary practice? ☐ Yes ☒ No

Is this office handicapped accessible? ☐ Yes ☐ No ☒ Unknown

Is this office accessible to public transportation? ☐ Yes ☐ No ☒ Unknown

☒ Verify & Next ☐ Close

Figure 103: Verify Service Location

- Click **Verify & Next** to confirm the information is correct.
- OR-
- Update the information as necessary. Click **Verify & Next**.
- OR-

- Click the **Check here if this location should be removed from our records** checkbox to remove the location from Beacon's records. Click **Verify & Next**. Once the service location information is verified, the system displays any programs associated with the location.

(Program information relates to the location shown above)

Program Description	Number of Units	Age - Range	Program Director	Program Director Licensure	Facility / Program License Number	No Longer Offered
INPATIENT PSYCHIATRIC ADULT	0	18 - 999				<input type="checkbox"/>
INPATIENT PSYCHIATRIC CHILD	0	0 - 12				<input type="checkbox"/>
INPATIENT PSYCHIATRIC ADOLESCENT	0	13 - 17				<input type="checkbox"/>
RESIDENTIAL PSYCHIATRIC ADULT	0	18 - 999				<input type="checkbox"/>
RESIDENTIAL PSYCHIATRIC CHILD	0	0 - 12				<input type="checkbox"/>
RESIDENTIAL PSYCHIATRIC ADOLESCENT	0	13 - 17				<input type="checkbox"/>
CASE MANAGEMENT ADULT	0	18 - 999				<input type="checkbox"/>
CASE MANAGEMENT CHILD	0	0 - 12				<input type="checkbox"/>
CASE MANAGEMENT ADOLESCENT	0	13 - 17				<input type="checkbox"/>
ELECTROCONVULSIVE OUTPATIENT THERAPY	0	0 - 999				<input type="checkbox"/>
ELECTROCONVULSIVE INPATIENT THERAPY	0	0 - 999				<input type="checkbox"/>
FOSTER CARE ADULT	0	18 - 999				<input type="checkbox"/>
FOSTER CARE CHILD	0	0 - 12				<input type="checkbox"/>
FOSTER CARE ADOLESCENT	0	13 - 17				<input type="checkbox"/>
OUTPATIENT PSYCHIATRIC	0	0 - 999				<input type="checkbox"/>
PARTIAL HOSP PSYCHIATRIC ADULT	0	18 - 999				<input type="checkbox"/>
PARTIAL HOSP PSYCHIATRIC CHILD	0	0 - 12				<input type="checkbox"/>
PARTIAL HOSP PSYCHIATRIC ADOLESCENT	0	13 - 17				<input type="checkbox"/>
RESPIRE SERVICES	0	0 - 999				<input type="checkbox"/>
SUPPORTED EMPLOYMENT SERVICES ADULT	0	18 - 999				<input type="checkbox"/>
SUPPORTED EMPLOYMENT SERVICES ADOLESCENT	0	13 - 17				<input type="checkbox"/>
If no changes need to made , select this checkbox to acknowledge all program information shown above is correct.						<input type="checkbox"/>

Figure 104: Verify Programs

- Review the program information and make any necessary updates.
- Click **Verify & Save** when finished.

Click **Save & Next** to continue.

6. Complete the Program Addenda Questionnaire. Click **Save & Next** to continue.

6. Program Addenda Questionnaire

If you answer No to any of the questions below, please provide a written explanation and include the practice location(s) to which the explanation applies in the Comment box related to the section.

Inpatient Psychiatric

1. Does your facility provide 24 hours/ 7 day per week skilled nursing staff coverage? ☐ Y ☐ N
2. Does your facility accept admissions 24 hours a day / 7 days per week? ☐ Y ☐ N
3. Does your program have written admission and discharge criteria? ☐ Y ☐ N
4. Does your facility provide medical diagnostic services on-site or by contract? ☐ Y ☐ N
5. Does your facility provide a full range of treatment programming 7 days per week, with structured programming provided a minimum of 6 hours per day? ☐ Y ☐ N
6. Does your facility provide individualized treatment plans? ☐ Y ☐ N
7. Are emergency psychiatric/medical services available on-site or by contract? ☐ Y ☐ N
8. Does your program have oversight by a medical director? ☐ Y ☐ N
9. Must have an initial visit with an attending physician within 24 hours of admission for evaluation and treatment planning and a documented daily visit with an attending licensed prescribing provider. ☐ Y ☐ N

Comments:

Residential Treatment Program/RTC

1. Does your facility provide 24 hours/ 7 day per week supervision of residents by a skilled licensed staff? ☐ Y ☐ N
2. Does your facility provide multidisciplinary licensed staff (i.e. nurses, social workers, counselors, etc.)? ☐ Y ☐ N
3. Does your program have written admission and discharge criteria? ☐ Y ☐ N
4. Does your facility provide a full range of social and recreational therapies? ☐ Y ☐ N
5. Does your facility provide individualized treatment plans? ☐ Y ☐ N
6. Does your facility provide a full range of treatment programming 7 days per week, with structured programming provided a minimum of 6 hours per day? ☐ Y ☐ N
7. Does your facility require and/or encourage family involvement in treatment? ☐ Y ☐ N
8. Are emergency psychiatric/medical services available on-site or by contract? ☐ Y ☐ N
9. Does your program have oversight by a medical director? ☐ Y ☐ N
10. Does your facility perform criminal background checks on staff? ☐ Y ☐ N
11. Does your facility have a documented patient visit with a Psychiatrist at least 1 time per week? ☐ Y ☐ N

Comments:

Partial Hospitalization

1. Does your facility/program provide supervision by a physician? ☐ Y ☐ N
2. Does your facility/program have written Admission and Discharge criteria? ☐ Y ☐ N
3. Does your facility/program provide physician medication management? ☐ Y ☐ N
4. Does your facility/program staffing include psychiatry, nursing, psychology, and social work? ☐ Y ☐ N
5. Does your facility/program have chemical dependency education and treatment (CD only) ☐ Y ☐ N
6. Does your facility/program provide individualized treatment plans? ☐ Y ☐ N
7. Does your facility/program have a full program schedule to provide individual and group therapy? ☐ Y ☐ N
8. Does your program have oversight by a medical director? ☐ Y ☐ N
9. Must have a documented patient visit with a Psychiatrist at least 1 time per week. (Psych only) ☐ Y ☐ N
10. Does your facility/program operate at least 3 to 5 days/week and at least a minimum of 6 hours/day? ☐ Y ☐ N

Indicate program days and hours of operation:

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

Comments:

RESPITE CARE

1. Does your agency use specially-trained staff to implement the treatment plan? ☐ Y ☐ N
2. Does your agency have written policies explaining the procedures and criteria for respite provider training and selection? ☐ Y ☐ N
3. Does your agency provide medical consultation 24 hours a day / 7 days per week? ☐ Y ☐ N
4. Does your agency provide 24 hours a day / 7 days per week supervision of residents? ☐ Y ☐ N
5. Does your agency provide written procedures for handling medical and/or psychiatric emergencies? ☐ Y ☐ N
6. Does your agency require and/or encourage family involvement in treatment? ☐ Y ☐ N
7. Does your program have oversight by a director who is a licensed clinician? ☐ Y ☐ N

Comments:

ELECTROCONVULSIVE OUTPATIENT THERAPY

1. There are no questions associated with this program.

Comments:

ELECTROCONVULSIVE INPATIENT THERAPY

1. There are no questions associated with this program.

Comments:

Figure 105: Addenda Information

7. Follow the directions on this page to complete and upload any additional contract-specific Supporting Documentation as necessary. Click **Save & Next** to continue.

7. SUPPORTING DOCUMENTATION

Specific contracts may require additional documentation to complete the rec credentialing process. Please go to our website and check the Credentialing Supporting Documents section on the Administrative Forms page via the below link to access any applicable contract specific documents to print, complete and then upload to this page to submit. If you are unable to upload the necessary document(s), please fax to 1-866-612-7795.

<http://www.valueoptions.com/providers/Adminforms.htm>


Open	Name	Date/Time Uploaded	Delete
<div style="display: flex; justify-content: space-between; margin-top: 10px;">  Upload  Save & Next </div>			

Figure 106: Supporting Documentation


8. Use the Roster of Providers page to:
 - Manually add providers to the roster
 - Make any necessary corrections to the existing roster
 - Upload a copy of a staff roster

Click **Next** to continue.

8. ROSTER OF PROVIDERS

Roster of Providers

Please add any providers not listed below and make necessary corrections to your existing roster of providers. You may also upload a copy of a staff roster generated in your own format.

Edit	Name	Title	NPI	Status	Delete
<div style="display: flex; justify-content: space-between; margin-top: 10px;">  Add Provider </div>					

Uploaded Roster Files

View	File Name	Document Type	Upload Date
Total:0			



 Upload Roster
 Next

Figure 107: Roster of Providers

9. Read the Participation Statement. If manually signing and faxing the Participation form, follow the instructions on this page. (After indicating their intention to fax the form, users should print the document *prior to saving*.) (Refer to the [Electronically Sign the Attestation](#) section of the [Provider Data Sheet](#) chapter for detailed information.)

9. PARTICIPATION STATEMENT

For purposes of making this application for participation in the ValueOptions[®], Inc. provider network, the Facility/Program certifies that all information provided to ValueOptions[®] is true and correct to the best of the Facility/Program's knowledge. The Facility/Program agrees to notify ValueOptions[®] promptly if there are any material changes in the information provided, whether prior to or after the Facility/Program's acceptance as a ValueOptions[®] participating provider. The Facility/Program understands and agrees that if ValueOptions[®] discovers that this application contains any significant misstatement, misrepresentations or omissions, ValueOptions[®] may void, in its sole discretion, its application and any related participating provider agreements.

The Facility/Program authorizes ValueOptions[®] and its Credentialing Verification Organization (CVO) to consult with State licensing agencies, accreditation bodies, malpractice insurance carriers, and, upon notification to Facility/Program of additional specific entities or organizations, any other entity from which information may be needed to complete the credentialing process, and the Facility/Program authorizes the release of such information to ValueOptions[®] and its CVO. The Facility/Program releases ValueOptions[®] and its CVO and its employees and agents and all those whom ValueOptions[®] contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating the Facility/Program's application.

The Facility/Program further understands and agrees that: (a) the Facility/Program is responsible for producing all information required or requested by ValueOptions[®] and its CVO in connection with this application; (b) ValueOptions[®] is under no obligation to complete the processing of this application until such information is provided by the Facility/Program; (c) in the event that ValueOptions[®] decides not to accept the Facility/Program as a participating provider and the Facility/Program desires to have this decision reviewed, the Facility/Program will appeal such determination to the ValueOptions[®] Provider Appeals Committee ("PAC").

➔

[Click here to sign this document electronically](#)

OR

➔
☐ Check here if you intend to fax the Attestation form

Faxing Instructions

➔ **PRINT ([Click Here](#)) AND FAX SIGNED ATTESTATION WITHIN 5 DAYS TO:**

ValueOptions, Inc.
National Network Operations
FAX: 1-866-612-7795

If you have any questions regarding the application, please call 1-800-397-1630

ValueOptions[®], Inc. is an equal opportunity organization, which does not discriminate on the basis of race, color, sex, national origin, religion, age, disability, or veteran status in admission or access to or treatment or employment in its programs and activities. Applicants who may have inquiries regarding our policy and procedures should contact the National Network Development and Management Department.

Save

Figure 108: Participation Information


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Update Demographic Information

This functionality allows a provider to see all his/her active service locations along with the associated telephone numbers, fax numbers, and billing locations. Providers make and submit changes as needed from within ProviderConnect.

To update demographic information, click on [Update Demographic Information](#). (This link is controlled outside the application. Providers have access to this link only at certain times.)

The Provider Demographics Summary page displays.

A  icon is available on the various demographics pages that displays additional information upon pausing on the icon.




This page contains the following sections.

- Provider Demographics
- Service Location Information

Provider Demographics

Provider
VO TEST PROVIDER13 TEST

Mailing Address: ?

	ID:	559718
	Address:	3001 ELM AVE BALTIMORE, MD 21211-2721 Country: US
	Phone:	575 - 111 - 1111 Ext: 444
	Fax:	655 - 435 - 3434 Ext: 333
	ProviderConnect Email: ?	MXE@MXE.COM
	Correspondence Email: ?	JUNK@JUNK.COM

Service Location Information ?

The list below shows the current Service Locations for the Provider shown above.
If you would like to view the Service Address' corresponding Billing Location, click the green "Show" tab to expand the selection.

Sort By: [ID](#) [Name](#) [City](#) [State](#)





























Service Address ?		Corresponding Billing Address ?												
This Location is set to expire on: 11/19/2013														
1 ?	<table> <tr> <td rowspan="5"></td> <td rowspan="5"></td> <td>ID:</td> <td>A000008</td> </tr> <tr> <td>Name:</td> <td>PRETZEL K MISTER MD</td> </tr> <tr> <td>Address:</td> <td>7740 SHRADER RD STE C RICHMOND, VA 23228-2500 Country: US</td> </tr> <tr> <td>Phone: *</td> <td>(111) 333 - 3333 333</td> </tr> <tr> <td>Fax:</td> <td>(999) 999 - 9999 999</td> </tr> </table>			ID:	A000008	Name:	PRETZEL K MISTER MD	Address:	7740 SHRADER RD STE C RICHMOND, VA 23228-2500 Country: US	Phone: *	(111) 333 - 3333 333	Fax:	(999) 999 - 9999 999	 BILLING LOCATION
				ID:	A000008									
				Name:	PRETZEL K MISTER MD									
				Address:	7740 SHRADER RD STE C RICHMOND, VA 23228-2500 Country: US									
				Phone: *	(111) 333 - 3333 333									
		Fax:	(999) 999 - 9999 999											
This Location is set to expire on: 12/31/2013														
2 ?	<table> <tr> <td rowspan="5"></td> <td rowspan="5"></td> <td>ID:</td> <td>A365230</td> </tr> <tr> <td>Name:</td> <td>MARYLAND GENERAL HLTH CARE</td> </tr> <tr> <td>Address:</td> <td>1113 N ROLLING RD CATONSVILLE, MD 21228-3827 Country: US</td> </tr> <tr> <td>Phone: *</td> <td>(222) 111 - 1111</td> </tr> <tr> <td>Fax:</td> <td>(111) 111 - 1111</td> </tr> </table>			ID:	A365230	Name:	MARYLAND GENERAL HLTH CARE	Address:	1113 N ROLLING RD CATONSVILLE, MD 21228-3827 Country: US	Phone: *	(222) 111 - 1111	Fax:	(111) 111 - 1111	 BILLING LOCATION
				ID:	A365230									
				Name:	MARYLAND GENERAL HLTH CARE									
				Address:	1113 N ROLLING RD CATONSVILLE, MD 21228-3827 Country: US									
				Phone: *	(222) 111 - 1111									
		Fax:	(111) 111 - 1111											
This Location is set to expire on: 12/11/2013														
3 ?	<table> <tr> <td rowspan="5"></td> <td rowspan="5"></td> <td>ID:</td> <td>A381184</td> </tr> <tr> <td>Name:</td> <td>MILLS EYE HOSPITAL</td> </tr> <tr> <td>Address:</td> <td>PO BOX 719 PHILADELPHIA, PA 19105-0719 Country: US</td> </tr> <tr> <td>Phone: *</td> <td>(215) 928 - 3322</td> </tr> <tr> <td>Fax:</td> <td></td> </tr> </table>			ID:	A381184	Name:	MILLS EYE HOSPITAL	Address:	PO BOX 719 PHILADELPHIA, PA 19105-0719 Country: US	Phone: *	(215) 928 - 3322	Fax:		 BILLING LOCATION
				ID:	A381184									
				Name:	MILLS EYE HOSPITAL									
				Address:	PO BOX 719 PHILADELPHIA, PA 19105-0719 Country: US									
				Phone: *	(215) 928 - 3322									
		Fax:												
This Location is set to expire on: 12/11/2013														
4 ?	<table> <tr> <td rowspan="5"></td> <td rowspan="5"></td> <td>ID:</td> <td>A625116</td> </tr> <tr> <td>Name:</td> <td>RETTTTTT ME</td> </tr> <tr> <td>Address:</td> <td>1560 WILSON BLVD #203 ARLINGTON, VA 22201 Country: US</td> </tr> <tr> <td>Phone: *</td> <td>(223) 333 - 4444 777</td> </tr> <tr> <td>Fax:</td> <td>(454) 433 - 2327 3322</td> </tr> </table>			ID:	A625116	Name:	RETTTTTT ME	Address:	1560 WILSON BLVD #203 ARLINGTON, VA 22201 Country: US	Phone: *	(223) 333 - 4444 777	Fax:	(454) 433 - 2327 3322	 BILLING LOCATION
				ID:	A625116									
				Name:	RETTTTTT ME									
				Address:	1560 WILSON BLVD #203 ARLINGTON, VA 22201 Country: US									
				Phone: *	(223) 333 - 4444 777									
		Fax:	(454) 433 - 2327 3322											

Figure 109: Provider Demographics Summary Example

Provider Demographics

The top portion of the Provider Demographics Summary page displays the provider's mailing address along with other provider-related information.

1. Click the “edit” () icon to update provider demographic information.

The Enter & Verify Mailing Address page displays.

2. Edit the following information as necessary.
 - Address Line 1/Line 2
 - City/State/Zip Code
 - Country
 - Phone #
 - Phone extension
 - Fax #
 - Fax extension
 - Website address
 - ProviderConnect E-mail (Verify e-mail)
 - Correspondence E-mail (Verify e-mail)



Figure 110: Enter & Verify Mailing Address





Upon clicking **Continue**, the user is presented with three options.

- **Cancel** – Cancels the changes and returns the user to the Provider Demographics Summary page.
- **Back** – Returns the user to the previous page.
- **Submit** – Sends the changes to Network Operations. Once a decision is made by Network Operations to approve or reject a specific change, the system sends a message to the provider's message center indicating the status of the update.

While on the Enter & Verify Mailing Address page, the user can also cancel any changes or reset the page.


Service Location Information

The bottom portion of the Provider Demographics Summary page displays the provider's service locations.

- Clicking the SHOW () icon reveals the billing location for a specific service location.
- Clicking the HIDE () icon re-hides the billing information.
- Clicking the Show Hours () icon expands the office hours display, allowing the provider to add and update service location office hours.
- Clicking the Hide Hours () icon collapses the office hours display.

Edit a Service Location

Providers have the ability to edit service locations. To edit a service location:

1. Click the “edit” () icon for the appropriate record.
2. Select between the following name formats by moving the right-pointing blue arrow up or down.
 - First MI Last
 - Facility/Group Name
3. Edit the following information as necessary.
 - Location name

Note: Editable only if the location does not have a tax ID.
 - Phone #
 - Phone extension
 - Fax #
 - Fax extension
 - Office Hours
4. Click **Save**.

1 ?	ID:	GA001282																																																			
	Provider Type:																																																				
	Name:	First	MI	Last	Title:																																																
		<div>OR:</div> <div>Facility/Group Name</div> <div>BUCHANAN HH</div>																																																			
	Address:	1119 FIELDSTONE DR CANTON, GA 30114 Country: US																																																			
	Phone:	(770)	324	- 2997	Ext:																																																
	Fax:	()		-	Ext:																																																
	Office Hours:	<table border="1"> <thead> <tr> <th colspan="2">Monday</th> <th colspan="2">Tuesday</th> </tr> </thead> <tbody> <tr> <td>From</td> <td>SELECT</td> <td>SELECT</td> <td>SELECT</td> </tr> <tr> <td>To</td> <td>SELECT</td> <td>SELECT</td> <td>SELECT</td> </tr> <tr> <th colspan="2">Wednesday</th> <th colspan="2">Thursday</th> </tr> <tr> <td>From</td> <td>SELECT</td> <td>SELECT</td> <td>SELECT</td> </tr> <tr> <td>To</td> <td>SELECT</td> <td>SELECT</td> <td>SELECT</td> </tr> <tr> <th colspan="2">Friday</th> <th colspan="2">Saturday</th> </tr> <tr> <td>From</td> <td>SELECT</td> <td>SELECT</td> <td>SELECT</td> </tr> <tr> <td>To</td> <td>SELECT</td> <td>SELECT</td> <td>SELECT</td> </tr> <tr> <th colspan="2">Sunday</th> <td colspan="2"></td> </tr> <tr> <td>From</td> <td>SELECT</td> <td colspan="2"></td> </tr> <tr> <td>To</td> <td>SELECT</td> <td colspan="2"></td> </tr> </tbody> </table>				Monday		Tuesday		From	SELECT	SELECT	SELECT	To	SELECT	SELECT	SELECT	Wednesday		Thursday		From	SELECT	SELECT	SELECT	To	SELECT	SELECT	SELECT	Friday		Saturday		From	SELECT	SELECT	SELECT	To	SELECT	SELECT	SELECT	Sunday				From	SELECT			To	SELECT		
Monday		Tuesday																																																			
From	SELECT	SELECT	SELECT																																																		
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From	SELECT	SELECT	SELECT																																																		
To	SELECT	SELECT	SELECT																																																		
Friday		Saturday																																																			
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To	SELECT	SELECT	SELECT																																																		
Sunday																																																					
From	SELECT																																																				
To	SELECT																																																				






Figure 111: Edit a Service Location

Providers also have the ability to remove a specific service location. The following message displays: “If this location is being replaced by a new location, please select **Cancel** and add the new location first via the ‘Add New Service Address’ button below. You will be prompted during the process on whether the new location is replacing an existing one. Otherwise, if this location is not being replaced, please select **OK** to continue.”

Invalidate a Service Location

A checkbox is available on the Service Location Information page that enables providers to invalidate a particular service location. Upon selecting this checkbox, a pop-up window displays advising the provider to contact MMIS to have the information updated.



Used only for the attestation process.

Service Location Information

The list below shows the current Service and Associated Billing Locations for the Provider shown above.

Sort By: ID Name City State

Service Address

1

ID: A383218
☐ Check this box if this location is no longer valid

Provider Type: RESIDENTIAL TREATMENT CENTER

Name: EDGEMADE AT UPPER MARLBORO

Address: 13400 EDGEMADE RD
UPPER MARLBORO, MD 20772-8088
Country: US

Phone:

Fax:

Office Details

Monday
Tuesday

From
To

Wednesday
Thursday

From
To

Friday
Saturday

From
To

Sunday

From
To

Accepting New Patients: Yes

Email Address:

Website:

Disability Access:

Corresponding Billing Address

1

ID: A383217

Name: EDGEMAD PSYCHIATRIC REHAB SVC PR

Address: 13400 EDGEMADE RD
UPPER MARLBORO, MD 20772-8088
Country: US

Fed Tax Id: 521244811 Tax Id Type: EIN

Phone:

Fax:

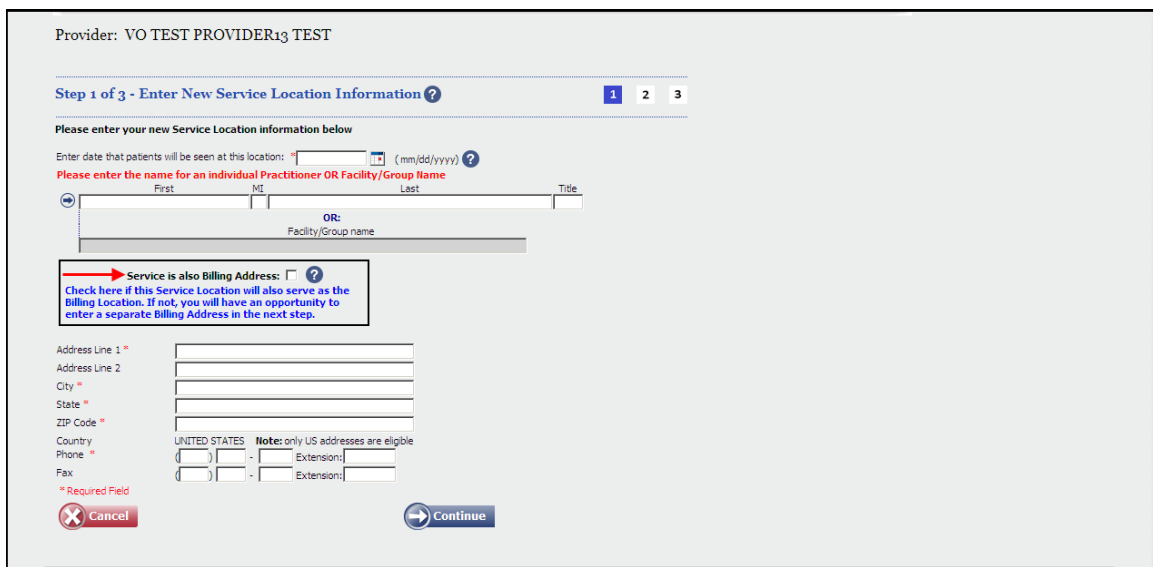
Figure 112: Invalidate a Service Location

Add a Service Address

Providers have the ability to add service addresses. To add a service address, click the **Add New Service Address** button. The Enter New Service Location Information page displays.

Depending on the person's answer to the **Service is also Billing Address** question, this is either a two-step or three-step process.

- Two-Step Process – The service location is the same as the billing address. (Checkbox selected.)
- Three-Step Process – The service location is not the same as the billing address. (Checkbox not selected.)



Provider: VO TEST PROVIDER13 TEST

Step 1 of 3 - Enter New Service Location Information ? 1 2 3

Please enter your new Service Location information below

Enter date that patients will be seen at this location: (mm/dd/yyyy) ?

Please enter the name for an individual Practitioner OR Facility/Group Name

First MI Last Title

OR:

Facility/Group name

Service is also Billing Address: ?

Check here if this Service Location will also serve as the Billing Location. If not, you will have an opportunity to enter a separate Billing Address in the next step.

Address Line 1 *

Address Line 2 *

City *

State *

ZIP Code *

Country *

Phone *

Fax *

UNITED STATES Note: only US addresses are eligible

Extension: *

Extension: *

* Required Field

Cancel Continue

Figure 113: Add a Service Location

Two-Step Process

Step 1 of 2

Complete the follow information.

- Date patients will be seen at the new location
- Practitioner Name/Facility/Group Name
- Federal Tax ID
- Tax ID Type
- Address Line 1/Line 2
- City/State/Zip Code
- Country
- Phone #
- Phone extension

- Fax #
- Fax extension
- Office Hours

Upon clicking **Continue**, the QAS verification process verifies/standardizes the address.

Step 2 of 2

Answer the **Will this New Service Location replace an existing one?** question.

- If **Yes**, select the service location to replace. (This location will be terminated.)
-or-
- If **No**, the system selects the first provider/vendor combination encountered (in the same state) and proceeds to copy the location information into the new service location. (If the provider does not have any existing locations in the same state, the system displays an error message.)

Three-Step Process

Step 1 of 3

Complete the follow information.

- Date patients will be seen at the new location
- Practitioner Name/Facility/Group Name
- Address Line 1/Line 2
- City/State/Zip Code
- Country
- Phone #
- Phone extension
- Fax #
- Fax extension
- Office Hours

Upon clicking **Continue**, the QAS verification process verifies /standardizes the address.

Step 2 of 3

Answer the **Will this New Service Location replace an existing one?** question.

- If **Yes**, select the service location to replace. (This location will be terminated.)
-or-
- If **No**, the system selects the first provider/vendor combination encountered (in the same state) and proceeds to copy the location information into the new service location. (If the provider does not have any existing locations in the same state, the system displays an error message.)

Upon clicking **Continue to Billing Selection**, the billing address maintenance page displays.

Step 3 of 3

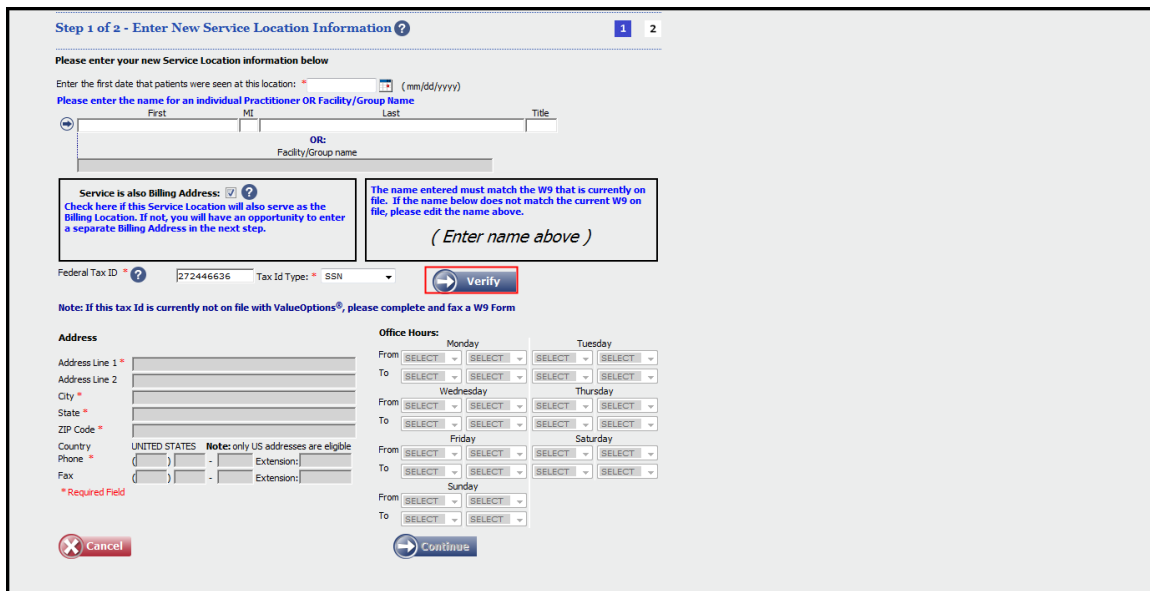
1. Optionally select a replacement billing location.
2. Enter the effective date of the change request.

Practitioners and facilities can also create new billing addresses.

Add a New Federal Tax ID

Providers have the ability to request the addition of Federal Tax IDs that do not already exist in NetworkConnect. To add a Federal Tax ID:

1. Enter the new tax ID in the **Federal Tax ID** field.
2. Select a tax ID type from the **Tax ID Type** drop-down.
3. Click **Verify**.



Step 1 of 2 - Enter New Service Location Information

Please enter your new Service Location information below

Enter the first date that patients were seen at this location: (mm/dd/yyyy)

Please enter the name for an individual Practitioner OR Facility/Group Name

First MI Last Title

OR:

Facility/Group name

Service is also Billing Address: ☒ [?](#)

Check here if this Service Location will also serve as the Billing Location. If not, you will have an opportunity to enter a separate Billing Address in the next step.

The name entered must match the W9 that is currently on file. If the name below does not match the current W9 on file, please edit the name above.

(Enter name above)

Federal Tax ID: 272446636 Tax ID Type: SSN **Verify**

Note: If this tax ID is currently not on file with ValueOptions®, please complete and fax a W9 Form

Address

Address Line 1 *

Address Line 2 *

City *

State *

ZIP Code *

Country: UNITED STATES Note: only US addresses are eligible

Phone: () - Extension: *

Fax: () - Extension: *

* Required Field

Office Hours:

Monday Tuesday

From: SELECT SELECT To: SELECT SELECT

Wednesday Thursday

From: SELECT SELECT To: SELECT SELECT

Friday Saturday

From: SELECT SELECT To: SELECT SELECT

Sunday

From: SELECT To: SELECT

Cancel **Continue**

Figure 114: Add a New Federal Tax ID

The system verifies whether or not the tax ID entered matches a tax ID currently on file.

- If a match is found, the system indicates as such.
- If a match is not found, the system displays a hyperlink for the provider to download a blank W-9 form to complete, save, and then upload or he/she can upload a previously saved W-9. The provider must also select a reason for requesting a new tax ID.

Step 1 of 2 - Enter New Service Location Information

12

Please enter your new Service Location information below

Enter the first date that patients were seen at this location: * (mm/dd/yyyy)

Please enter the name for an individual Practitioner OR Facility/Group Name

First	MI	Last	Title
OR: Facility/Group name			

Service is also Billing Address:

Check here if this Service Location will also serve as the Billing Location. If not, you will have an opportunity to enter a separate Billing Address in the next step.

The name entered must match the W9 that is currently on file. If the name below does not match the current W9 on file, please edit the name above.

(Enter name above)

Federal Tax ID * Tax ID Type: * SSN

Note: You have entered a Tax ID that is currently not on file with ValueOptions, please upload a supporting W-9 form using the Browse button given below and provide a reason.

[Download a W-9 form](#). (Please click the hyperlink to access our administrative forms section and download the "W-9 Form")

Document Location * Browse...

Reason for requesting a new Tax ID: * -- SELECT REASON --

Address

Address Line 1 *

Address Line 2 *

City *

State *

ZIP Code *

Country * UNITED STATES Note: only US addresses are eligible

Phone * () - Extension:

Fax () - Extension:

* Required Field

Cancel

Office Hours

	Monday	Tuesday
From	SELECT	SELECT
To	SELECT	SELECT
From	Wednesday	Thursday
To	SELECT	SELECT
From	Friday	Saturday
To	SELECT	SELECT
From	Sunday	
To	SELECT	



Continue

Figure 115: Download a W-9 Form

Billing Location Information

Providers have the ability to edit the billing information for a specific service location. They can also replace a specific billing location. If a provider chooses to replace a billing location, the billing address maintenance page displays for him/her to select the replacement location. (The provider *must* also enter the effective date of the change request.)

To edit a billing location:

1. Click the **SHOW** () icon for the appropriate record.
2. Click the “edit” () icon.
3. Edit the following information as necessary.
 - Phone #
 - Phone extension
 - Fax #
 - Fax extension
4. Click **Save**.

Both practitioners and facilities can create new billing locations by clicking the **Add New Billing Address** button on the billing address maintenance page. The provider can also add a new Federal Tax ID if needed. (Refer to the [Add a New Federal Tax ID](#) section of this chapter for detailed information.)

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Performance Report

The *Performance Report* section of ProviderConnect allows provider information to be entered and saved. Upon clicking [Performance Report](#), a performance report card displays.



		Report Title: ValueSelect Provider Performance Report Provider Name/Discipline/Provider #: JEANNE DECKER, PHD #002019 Reporting Period: 01/01/2009 to 12/31/2009	
VALUESELECT PERFORMANCE			
ON TRACK OUTCOMES		Your Results	
Registered for On Track?	NO	Date: NA	Standard: Registered
Number of Client Feedback Forms submitted:	0		
Number of distinct patients with forms submitted:	0		
PATIENT TREATMENT SURVEY		Your Results	
<i>Survey Results - % of 'Yes' responses. (min. 5 surveys required for reporting.)</i>			
Number of completed surveys:	0		Standard: >=1
ELECTRONIC TRANSACTIONS		# Electronic	Total Transactions
Claims Filed Electronically	149	196	76%
			Standard (claims): >50%
PROVIDERCONNECT USAGE		Your Results	Last Login Date
Number of ProviderConnect Logins this period:	1	11/11/2009	Standard (logins): >=1
PERFORMANCE STANDARD SUMMARY		On Track Outcomes	Treatment Surveys
Meets Performance Standards:	NO	NO	YES
		Electronic Transactions	CEAP Credential
		YES	NO
		ProviderConnect Usage	Usage
		YES	YES
PRACTICE PATTERN SUMMARY		Your Patients Commercial	Your Patients Public Sector
		National Commercial Network Same Discipline	National Public Sector Same Discipline
DIAGNOSTIC SUMMARY		Total # Patients	% of Patients
Adjustment Disorders	2	9%	0
Anxiety and Stress Disorders	7	30%	0
Delirium, Dementia, Amnesic, Other Cognitive Disorders	0	0%	0
Disorders Diagnosed in Infancy, Childhood or Adolescence	0	0%	0
Dissociative, Somatoform, Factitious Disorders	1	4%	0
Eating Disorders	1	4%	0
Mental Disorders due to General Medical Condition	0	0%	0
Mood Disorders	11	48%	0
Personality Disorders	0	0%	0
Schizophrenia, Other Psychotic Disorders	1	4%	0
Substance Related Disorders	0	0%	0
Other Diagnosis/Mental Disorder	0	0%	0
EAP Cases	0	0%	0
Total:	23	100%	0

Figure 116: Performance Report Card

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Compliance

The *Compliance* section of ProviderConnect contains regulatory information, HIPAA information, resources, and technical assistance contact information. Click on [Compliance](#) to access the Compliance page.



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Compliance

It is the policy of ValueOptions® to comply with all local, state, and federal laws governing its operations; to conduct its affairs in keeping with the moral, legal and ethical standards of our industry; and to support the government's efforts to reduce healthcare fraud and abuse. The ValueOptions Corporate Compliance Program establishes a culture within the organization that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law, and federal, state, and private payor health care program requirements. Agents, subcontractors, vendors, and consultants who represent the company are expected to adhere to the Compliance Program. For more information, please read the Code of Conduct and Ethics in its entirety.

- [Privacy Statement](#)
- [National Provider Identifier \(NPI\)](#)
- [Fraud and Abuse](#)
- [ValueOptions' E-Commerce Initiative](#)
- [Code of Conduct and Ethics](#)
- [Client Specific Documents](#)

ValueOptions is also a HIPAA-compliant organization. Under HIPAA Privacy Rule at 164.514(h) a covered entity prior to making any disclosure permitted under the privacy regulations must (1) verify the identity of a person requesting protected health information (PHI) and the authority of such person to have access to protected health information under this regulation, if the identity or any such authority of such person is not known to the covered entity. Accordingly, ValueOptions requires that anyone requesting access to PHI be appropriately identified and authenticated. Members and personal representatives, for example, are required to provide the member identification number or subscriber number and the member's or subscriber's date of birth. You or your administrative staff are identified and authenticated in a number of ways and may be asked for your federal tax identification number (TIN), your national provider identification number (NPI), or physical address as part of this verification process. Having this information available prior to making contact with ValueOptions will expedite your request.

The links below provide additional information regarding submitting electronic HIPAA transactions to ValueOptions.

- [How to Submit Electronic Claims in HIPAA 837 Format](#)
- [Behavioral Health Revenue Codes Approved by NUBC \(PDF\)](#)

ECLW Resources

- [EDI Claims Link for Windows® 3.5 Quick Start Guide \(PDF\)](#)
(NOTE: Please read before installing EDI Claims Link 3.5)
- [EDI Claims Link for Windows® 3.5 User's Manual \(PDF\)](#)
- [EDI Claims Link for Windows® 3.5 \(Application\)](#)
- [How to Run ECLW Installation Video](#)
- [How to Run ECLW Update Video](#)
- [Provider and Patient Data Maintenance Video](#)
- [Institutional Claim Instructional Video](#)
- [Professional Claim Instructional Video](#)

ValueOptions EDI Resources

- [ValueOptions Companion Guide](#)
- [837 Implementation Guide Information](#)
- [Special Billing Instructions](#)

ValueOptions Claims and Authorization Resources

- [Guide To Online Authorization Requests \(PDF\)](#)
- [Guide To Direct Claim Submission for Professional Claims \(PDF\)](#)
- [Guide to Changing or Reprocessing Professional Claims Online \(PDF\)](#)
- [Guide to EAP Claim Submission Online \(PDF\)](#)

General Information

- [How to Send Secure E-mail to ValueOptions Employees \(WORD\)](#)
- [How to Setup a Secure Email Account \(PDF\)](#)
- [How to Check a Secure Email \(PDF\)](#)
- [Where to Learn More About HIPAA](#)

Contact Information If you need technical assistance, please contact us at (888) 247-9311.

Overview

- [Providers' Home](#)
- [Education Center](#)
- [Forms](#)
- [Network-Specific Websites](#)
- [Provider Handbook](#)
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ProviderConnect

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- [Getting Started](#)
- [Helpful Resources](#)

Figure 117: Compliance


- Read the Beacon policies and technical assistance information.
- Click on the links to access additional information.

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Provider Handbook

This section of ProviderConnect allows providers to access the Beacon Health Options Provider Handbook. The handbook is a guide to Beacon's policies and procedures for individual providers, affiliates, group practices, programs, and facilities. It provides important information regarding the managed care features incorporated in Beacon's provider contract. The handbook reflects the policies that are applicable to Beacon's "general" commercial product lines.

Click on [Handbooks](#) to access the provider handbook.



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Provider Handbook

The Provider Handbook outlines the ValueOptions® standard policies and procedures for individual providers, affiliates, group practices, programs and facilities. Providers are encouraged to carefully review the Handbook as well as visit the Network-Specific page to verify which policies and procedures are applicable to them.

This handbook is an extension of the provider agreement and includes guidelines on doing business with ValueOptions, including policies and procedures for individual providers, affiliates, group practices, programs and facilities. Together, the provider agreement, addenda, and this handbook outline the requirements and procedures applicable to participating providers in the ValueOptions network(s). This handbook replaces in its entirety the previous version.

Questions, comments and suggestions regarding this handbook should be directed to ValueOptions at (800) 397-1630.

Please click below to launch the Provider Handbook and the Provider Handbook Appendices. You will need [Adobe® Reader](#) to view the Handbook. If you do not have access to this software, you may download and install these applications on your computer.

[ValueOptions Provider Handbook \(PDF\)](#)

- Section 1.0 Overview
- Section 2.0 About ValueOptions
- Section 3.0 Contact Information
- Section 4.0 E-Commerce Initiative
- Section 5.0 Electronic Resources
- Section 6.0 Participating Providers
- Section 7.0 Credentialing & Re-Credentialing
- Section 8.0 Sanctions
- Section 9.0 Appeals of National Credentialing Committee (NCC)/Provider Appeals Committee (PAC) Decisions
- Section 10.0 Office Procedures
- Section 11.0 Services to Members
- Section 12.0 Participating Provider Complaints, Grievances & Appeals
- Section 13.0 Claims Procedures & E-Commerce Requirements
- Section 14.0 Utilization Management
- Section 15.0 Appeal of Adverse Determinations
- Section 16.0 Quality Management/Quality Improvement

Appendices

- [Appendix 1 Handbook Glossary \(PDF\)](#)
- Appendix 2 List of Forms & Reference Documents
 - [Clinical Criteria](#)
 - [Treatment Guidelines](#)
 - Resource Documents
 - [Member Rights \(English\) \(PDF\)](#)
 - [Member Rights \(Spanish\) \(PDF\)](#)
 - [EDI Resource Document – E-Support Services for ProviderConnect and Electronic Claims \(PDF\)](#)
 - [Provider Summary Voucher Form Sample \(PDF\)](#)
 - [CMS 1500 Claim Form \(Version 02/12\) \(PDF\)](#)
 - [Tips for Completing the CMS 1500 \(PDF\)](#)
 - [UB04 Claim \(PDF\)](#)
 - [Tips for Completing the UB04 \(PDF\)](#)
 - [Clinical Department Hours of Operation \(PDF\)](#)
 - Forms
 - [Administrative](#)
 - [Clinical](#)
 - [EAP](#)
- [Appendix 3: State/Government Program/Network Specific Provision and/or Supplements](#)
- [Appendix 4: Medicare Advantage Specific Provisions \(PDF\)](#)
- [Appendix 4A: New York State Specific – Medicare Advantage/Medicare-Medicaid Dual Eligible Required Provisions \(Fully Integrated Duals Advantage \(FIDA\)\) \(PDF\)](#)
- [Appendix 5: EAP Handbook \(PDF\)](#)
- [Appendix 5A: MOS Handbook \(PDF\)](#)

Provider Handbook Updates

- [Provider Handbook Updates and Edits Log \(PDF\)](#)

Important Notice

ValueOptions reserves the right to interpret and construe any terms or provisions in this Handbook and to amend it, at its sole discretion, at any time. To the extent that there is an inconsistency between the Handbook and the provider contract, ValueOptions reserves the right to interpret such inconsistency. ValueOptions' interpretation shall be final and binding.

Overview

- Providers' Home
- Education Center
- Forms
- Network-Specific Websites
- Provider Handbook
- Contact Information

ProviderConnect

- Log In
- Capabilities and Benefits
- Getting Started
- Helpful Resources

Figure 118: Provider Handbook

Information on the following topics can be accessed from this page.

- Clinical Criteria
- Treatment Guidelines
- Member Rights
- Tips for Completing the CMS-1500 Claim Form

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Forms

Users can select, view, and print a variety of forms in this section of ProviderConnect. Click on **Forms** to access the Provider Online Services page.

1. Click on [Forms](#) to expand the section.
2. Select a **Type of Form** from the options that appear in the expanded section.
3. Click on the applicable [Form Name](#).


Some examples of the forms that can be accessed from this page are:

- CMS-1500 Claim Form
- UB04 Claim Form
- Outpatient Treatment Report Forms
- Inpatient and Higher Levels of Care Authorization Requests
- Psychological Evaluation Forms

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Network-Specific Information

Users can access network-specific information in this section of ProviderConnect. Click on [Network Specific Information](#) to access the Network-Specific page.



Site Search

[HOME](#)
[CLIENTS](#)
[MEMBERS](#)
[PROVIDERS](#)
[MOBILE](#)

[PRODUCTS & SERVICES](#)
[ABOUT US](#)
[NEWS](#)
[CONTACT US](#)
[AWARDS](#)
[CAREERS](#)

Network-Specific

- Applied Behavior Analysts
- California Counties (CMHDA)
- Charter Oak Behavioral Health
- ValueOptions® Colorado Partnerships for Colorado Medicaid
- Connecticut Behavioral Health Partnership (CT BHP)
- Emblem Behavioral Health Services Program
- Empire Plan
- Evergreen Health Care (EHC) and Evergreen Health Insurance (EHI)
- First Coast Advantage (FCA) – Molina Transition
- Florida Health Partners
- Franciscan Missionaries of Our Lady Health System
- Fully Integrated Duals Advantage (FIDA)
- Georgia Collaborative
- Group Insurance Commission – GIC (Beacon Health Strategies)
- Horizon Behavioral Health®
- Horizon Behavioral Health® – ABA Providers
- Horizon NJ Health
- Illinois Mental Health Collaborative for Access and Choice
- Kaiser Permanente of Northern California
- Kaiser Permanente of Southern California
- Long Island Behavioral Health Management
- Massachusetts Behavioral Health Partnership
- MedStar Family Choice
- MedStar Family Choice – DC Medicaid
- Michelin
- Michigan Engagement Center
- Military OneSource
- MVP Health Care
- New York City Health Plans
- North Carolina Health Choice
- North Carolina Medicaid
- NC State Health Plan (PPO)
- NCOC State Government and HealthPlans
- North Florida Behavioral Health Partners
- Northeast Engagement Center Health Plans
- NorthSTAR
- Rocky Mountain Health Plans®
- Telehealth
- United States Coast Guard
- University of Maryland Health Advantage
- Value Behavioral Health of Pennsylvania
- ValueOptions® Arkansas
- ValueOptions® of California
- ValueOptions® of Kansas
- ValueOptions® Maryland
- Warrior Assistance Program

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Figure 119: Network-Specific Information

Some examples of network-specific information that can be accessed from this page are:

- Beacon Health Options Colorado Partnerships for Colorado Medicaid
- North Carolina Medicaid
- NorthSTAR
- Beacon Health Options of California

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Education Center

A user can access articles, training/workshops, and provider tools in the *Education Center* section of ProviderConnect. Click on [Education Center](#) to access the Provider Online Services page.

1. Click on [Education Center](#) to expand the section.
2. Click on the applicable topic link.

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ValueSelect Designation

Users can access a description of the ValueSelect Network Program by clicking on [ValueSelect Designation](#).



ValueSelectSM Program Description

The ValueSelectSM designation recognizes network outpatient providers for engaging in activities that promote clinical effectiveness, member access to services, member satisfaction, and administrative efficiency. ValueSelectSM providers are eligible for a number of valuable benefits, including distinction in our provider referral search engine.

ValueSelect Eligibility Criteria

To promote continued network excellence, ValueOptions[®] has updated the program criteria for 2011. Over 4,000 providers currently qualify for the ValueSelectSM designation.

Providers are eligible for ValueSelectSM based on the following criteria, which will be implemented beginning with the Spring 2011 eligibility review cycle:

- **Accessibility:** Seeing five or more ValueOptions[®] members in the past 12 months (or at least 10 commercial members for clinics), and,
- **Administrative efficiency:** conducting transactions using ValueOptions[®] ProviderConnectSM portal within the past 12 months, and,
- **ValueSelect Activities:** Engaging in one or more of the following activities -
 - Participation in the On Track Outcomes Program
 - Submitting at least 75% of non-EAP claims electronically
 - Having clients complete the ValueOptions[®] Patient Treatment Survey
 - Having a CEAP credential

As part of its semi-annual designation process, ValueOptions[®] also reviews any complaints received for a provider within the past 2 years. An excessive number of complaints that are considered substantiated will disqualify a provider from ValueSelectSM.

To help providers monitor their performance on ValueSelectSM and other practice pattern metrics, ValueOptions[®] distributes a semi-annual ValueSelectSM Provider Performance Report. This report is available to high volume providers through the ProviderConnectSM web portal.

Benefits of the ValueSelectSM Designation

Outpatient providers who qualify for ValueSelectSM enjoy a number of benefits:


- **Opportunity for increased referrals** – ValueSelectSM providers are identified in the ValueOptions[®] provider search engine, ReferralConnect.
- **Free CEU/CMEs** – ValueOptions[®] has partnered with Essential Learning to provide online CEU courses at NO CHARGE to ValueSelectSM providers. Providers are able to access this web portal and sign up for self-paced online courses through ProviderConnect. In addition, ValueSelectSM providers receive invitations to participate in live CME, CEU or professional development (PDH's) seminars offered at no charge.
- **Training Discounts** – ValueOptions[®] has partnered with Behavioral Tech, LLC a nationally renowned evidenced-based practice (EBP) training firm. Behavioral Tech offers a 10% discount on training for ValueSelectSM providers.
- **Access to Achieve Solutions** – ValueSelectSM providers have access to Achieve Solutions[®], ValueOptions[®] award-winning website that offers valuable mental health resources, assessment tools and articles that may be shared with clients.

Figure 120: ValueSelect Network Program Description

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Contact Us

This section of ProviderConnect contains a summary of contact information. Click on [Contact Us](#) to access the Contact Us page.



Site Search

HOME
CLIENTS
MEMBERS
PROVIDERS
MOBILE

PRODUCTS & SERVICES
ABOUT US
NEWS
CONTACT US
AWARDS
CAREERS

Contact Us

Interested in joining the network?

Please call (800) 397-1630.

Claims - General Information

If you have questions about claims in general, call (800) 888-3944.

Claims Submission/ Address

Reference the address on the member's identification card, as the address may vary based on payment location.

Member Benefits, Eligibility, and Authorizations

If you have a question about authorization or benefits, call the (800) number on the back of the member's identification card.

Member Customer Service

To reach Member Customer Service, call the (800) number on the back of the member's identification card.

Provider Supporting Documentation

To send supporting documentation such as malpractice or insurance cover sheets please fax to (866) 612-7795

Regional Offices

If you have general questions and would like to contact Provider Relations in your region, visit the [list of our regional offices](#).

Electronic Claims Submission/ EDI Helpdesk

If you have a technical question about ProviderConnect (website), or EDI Claims Link, please contact the EDI Help Desk at (888) 247-9311 from 8 am — 6 pm Eastern Standard Time.

Fax: (866) 698-6032

E-mail: e-supportservices@valueoptions.com

Mailing Address:
ValueOptions®
Attn: EDI Helpdesk
PO Box 1287
Latham, NY 12110

Credentialing Status

To obtain information pertaining to your network status, contact our National Provider Line at (800) 397-1630 from 8 am - 8 pm Eastern Time.

Fraud and Abuse

Reports of fraud and abuse, or suspicions thereof, can be made in writing to:

Mailing Address:
ValueOptions®
Corporate Headquarters
ATTN: Special Investigations Unit
240 Corporate Boulevard, Suite 100
Norfolk, VA 23502

Clinical Appeals

To request a clinical appeal on a member's behalf, call the (800) number included in the adverse determination letter you received.

Administrative Appeal

To request an administrative appeal, call the (800) number included in the administrative denial letter you received.

Complaints/Grievances

To file a complaint/grievance, call the (800) number on the back of the member's identification card to speak to Customer Service.

Adverse Incident

Report all adverse incidents to the Clinical Care Manager with whom you conduct reviews.

Duty to Warn

Report all potential situations to the Clinical Care Manager with whom you conduct reviews.

Provider Coverage During Absences

Contact the Clinical Care Manager with whom you conduct reviews during absences (i.e. coverage while on vacation). Or call the number on the card to provide coverage information.

Changing your Provider Profile (e.g. Name, address)

"Change of Address" forms can be found at www.valueoptions.com and may be submitted by using one of the following options:

Fax: (866) 612-7795

Mail Address:
ValueOptions®
c/o Practitioner Maintenance
P.O. Box 41055
Norfolk, VA 23541

NOTE: A change of address requires an accompanying W-9 form which is also located at www.ValueOptions.com.

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- Providers' Home
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- Getting Started
- Helpful Resources

Figure 121: Contact Us

Some examples of contact information that can be accessed from this page are:

- Claims – General Information
- Provider Supporting Documentation
- Regional Offices

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Log Out of ProviderConnect

To log out of ProviderConnect, click the [Log Out](#) link in the upper right-hand corner of the screen. The login page redisplay.

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Role-Based Security

Overview

ProviderConnect offers the ability to control user access to sensitive areas within the application via role-based security. Providers can:

- Create New Login Accounts
- Deactivate Login Accounts
- Control User Access to Certain Areas within ProviderConnect

In addition to user roles, which are assigned either during ProviderConnect online registration or via FileConnect Admin, the system contains user statuses (that is, user types) that are also assigned via FileConnect Admin. These statuses are:

- Standard User –
 - Is not managed by another user
 - Does not manage other users
 - Has access to certain areas of ProviderConnect depending on his/her assigned user role and/or submitter type. For example:
 - Standard users with the user role of “Connecticut” have access to certain functions that other standard users may not.
 - Standard users with a submitter type of “General Claims Submitter” have access to certain functions that other standard users may not.
- Super User –
 - Is an administrative user
 - Manages other users’ login accounts
 - Has the ability to:
 - Create new login accounts
 - Deactivate (disable) a managed user
 - Control access to specific areas within ProviderConnect
- Managed User –
 - Is managed by a super user
 - Has access to only those functions to which he/she has been granted access

Managed users are associated to a particular super user via FileConnect Admin.



For a user to become a super user:

Contact the EDI Help Desk at 1-888-247-9311 from 8:00 am – 6:00 pm EST or by e-mail at e-support.Services@beaconhealthoptions.com. (The EDI Help Desk will set up your account and e-mail you once setup is complete. Please expect a turnaround time of 5 business days for completion.)

If a super user leaves the facility:

Contact the EDI Help Desk at 1-888-247-9311 from 8:00 am – 6:00 pm EST or by e-mail at e-support.Services@beaconhealthoptions.com. (The managed users can be reassigned to another super user by the EDI Help Desk. The super user's account will need to be deactivated by the EDI Help Desk.)

For a managed user to become a super user:

Contact the EDI Help Desk at 1-888-247-9311 from 8:00 am – 6:00 pm EST or by e-mail at e-support.Services@beaconhealthoptions.com. (The request must include at least one user that the super user will manage.)

Managing Users

As previously stated, super users can:

- [Create a new login account](#)
- [Control access to certain areas of ProviderConnect](#)
- [Deactivate a managed user](#)

Create a New Login Account

If a super user has existing managed users, he/she can create new login accounts by copying another managed user's account.

1. Click the [Manage Users](#) link on the main menu.

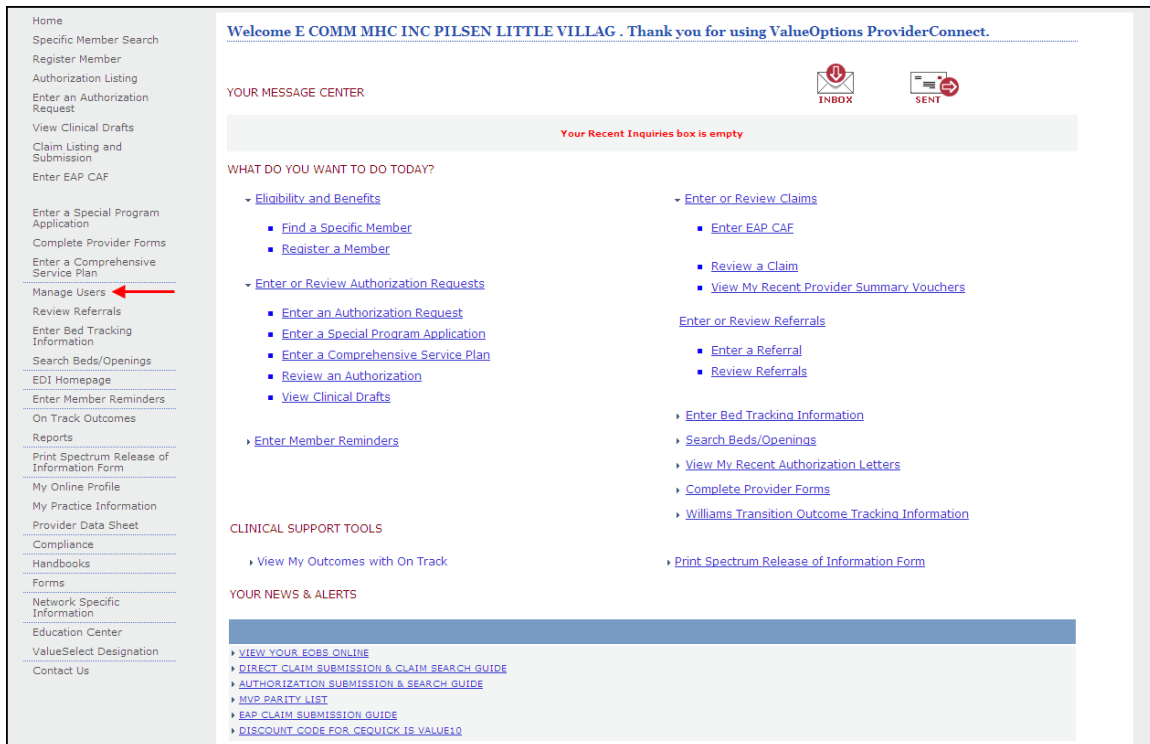


Figure 122: Manage Users Link

The Manage Users page displays.

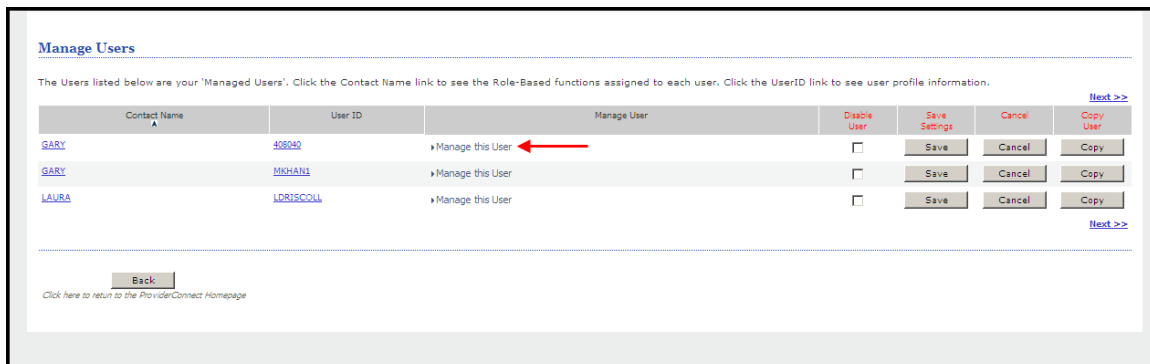


Figure 123: Manage this User

2. Click on the appropriate [Manage this User](#) link to create a duplicate account for a new user that contains the same attributes as the managed user who is being copied.

The following page displays.

Manage Users

The Users listed below are your 'Managed Users'. Click the Contact Name link to see the Role-Based functions assigned to each user. Click the UserID link to see user profile information.

Contact Name	User ID	Manage User	Disable User	Save Settings	Cancel	Copy User
GARY	408040	Manage this User	<input type="checkbox"/>	Save	Cancel	Copy

Function Category	Allow/Disallow
ADMINISTRATIVE	<input checked="" type="checkbox"/>
CLAIMS REVIEW	<input checked="" type="checkbox"/>
CLAIMS SUBMISSION	<input type="checkbox"/>
CLINICAL	<input checked="" type="checkbox"/>
CUSTOMER SERVICE	<input checked="" type="checkbox"/>
ELIGIBILITY	<input checked="" type="checkbox"/>
IMC CATEGORY	<input type="checkbox"/>
IMC CATEGORY	<input type="checkbox"/>
SUMMARY VOUCHERS	<input checked="" type="checkbox"/>
TINA CATEGORY	<input type="checkbox"/>

GARY	MKHANI	Manage this User	<input type="checkbox"/>	Save	Cancel	Copy
LAURA	LDNISCOLL	Manage this User	<input type="checkbox"/>	Save	Cancel	Copy

[Next >>](#)

[Back](#)

Click here to return to the ProviderConnect Homepage

Figure 124: Copy User

3. Click **Copy**.

The Copy User page displays with some of the fields already pre-populated.

Copy User

Required fields are denoted by an asterisk (*) adjacent to the label.

* User Login ID	<input type="text" value="KEYPOINT"/> (10 Characters Max)	Provider ID	<input type="text" value="MULTIPLE"/>
* First Name	<input type="text" value="HEALTH SERVICES"/>	Tax ID	<input type="text" value="APES"/>
* Last Name	<input type="text" value="GARY"/>	* Notify E-mail	<input type="text" value="gary@noname.org"/>
* Contact Name	<input type="text" value="GARY"/>	* Voice Phone	<input type="text" value="7035551212"/> Ext. <input type="text"/>
Address	<input type="text"/>	Fax Phone	<input type="text"/>
Address2	<input type="text"/>	* Password	<input type="text"/>
City/State	<input type="text"/>	* Secret Question	<input type="text"/>
Zip	<input type="text"/>	* Secret Answer	<input type="text"/>

[Clear All](#) [Cancel](#) [Submit](#)

Click to clear all the data entered above Click to cancel the 'Copy User' request Click to submit the 'Copy User' request

Figure 125: Copy User Page

- Edit any pre-populated information as necessary.
- Complete the remaining fields and click **Submit**.

Note: A red asterisk (*) indicates a required field.

Control Access to Certain Areas of ProviderConnect

If a super user has existing managed users, he/she can control a specific user's access to ProviderConnect.

1. Click the [Manage Users](#) link on the main menu.

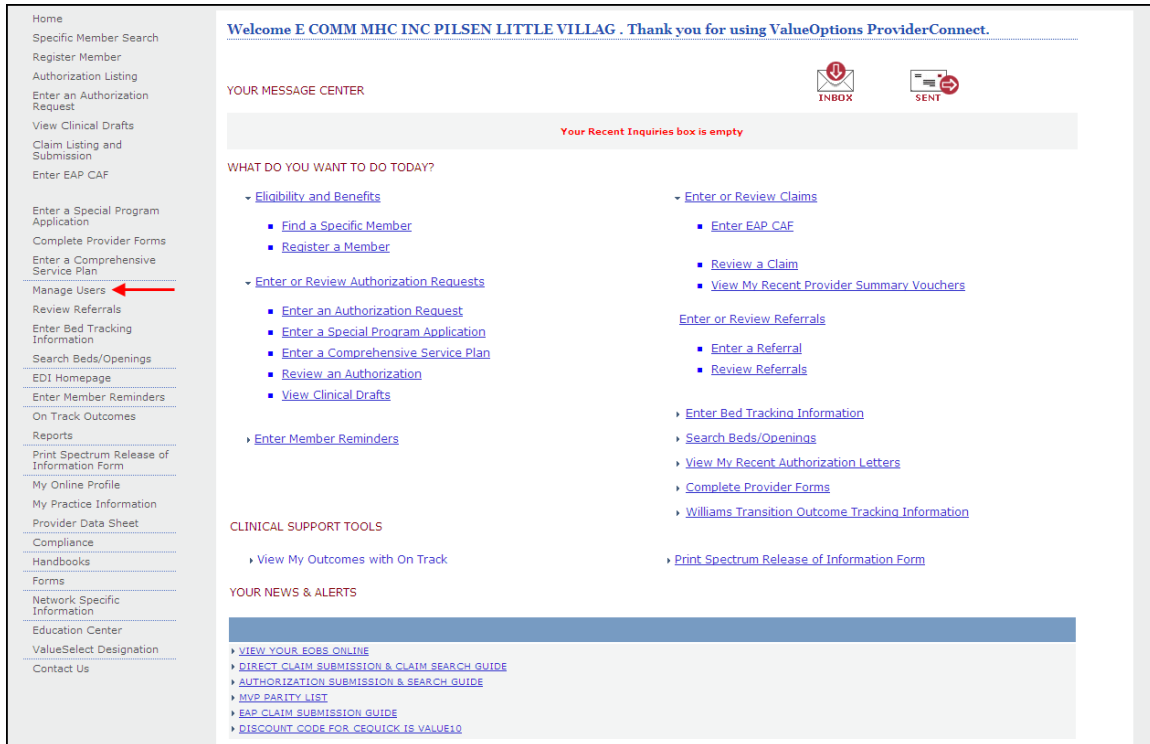


Figure 126: Manage Users Link

The Manage Users page displays.

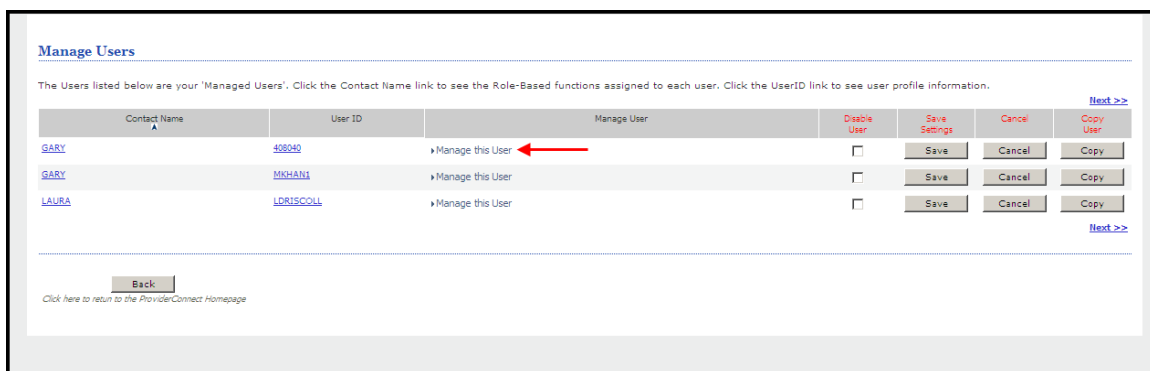


Figure 127: Manage this User

2. Click on the appropriate [Manage this User](#) link to expand the section.

Upon clicking [Manage this User](#), the following page displays where the user can allow access to a specific function category (e.g., Claims Review) by selecting the appropriate checkbox. (More than one category can be selected.)

Note

A logged in super user may not have access to all the function categories.



Manage Users

The Users listed below are your 'Managed Users'. Click the Contact Name link to see the Role-Based functions assigned to each user. Click the UserID link to see user profile information. [Next >>](#)

Contact Name	User ID	Manage User	Disable User	Save Settings	Cancel	Copy User																						
DR. PINTA'S STAFF	LCFINTA	Manage this User	<input type="checkbox"/>	Save	Cancel	Copy																						
<table border="1"> <thead> <tr> <th>Function Category</th> <th>Allow/Disallow</th> </tr> </thead> <tbody> <tr><td>ADMINISTRATIVE</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>CLAIMS REVIEW</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>CLAIMS SUBMISSION</td><td><input type="checkbox"/></td></tr> <tr><td>CLINICAL</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>CUSTOMER SERVICE</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>ELIGIBILITY</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>JMC CATEGORY</td><td><input type="checkbox"/></td></tr> <tr><td>JMC CATEGORY</td><td><input type="checkbox"/></td></tr> <tr><td>SUMMARY VOUCHERS</td><td><input checked="" type="checkbox"/></td></tr> <tr><td>TINA CATEGORY</td><td><input type="checkbox"/></td></tr> </tbody> </table>							Function Category	Allow/Disallow	ADMINISTRATIVE	<input checked="" type="checkbox"/>	CLAIMS REVIEW	<input checked="" type="checkbox"/>	CLAIMS SUBMISSION	<input type="checkbox"/>	CLINICAL	<input checked="" type="checkbox"/>	CUSTOMER SERVICE	<input checked="" type="checkbox"/>	ELIGIBILITY	<input checked="" type="checkbox"/>	JMC CATEGORY	<input type="checkbox"/>	JMC CATEGORY	<input type="checkbox"/>	SUMMARY VOUCHERS	<input checked="" type="checkbox"/>	TINA CATEGORY	<input type="checkbox"/>
Function Category	Allow/Disallow																											
ADMINISTRATIVE	<input checked="" type="checkbox"/>																											
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JMC CATEGORY	<input type="checkbox"/>																											
JMC CATEGORY	<input type="checkbox"/>																											
SUMMARY VOUCHERS	<input checked="" type="checkbox"/>																											
TINA CATEGORY	<input type="checkbox"/>																											
MEL	158250	Manage this User	<input type="checkbox"/>	Save	Cancel	Copy																						

[Next >>](#)

Figure 128: Function Categories

3. Click **Save** when finished.

Deactivate a Managed User

If a super user has existing managed users, he/she can deactivate (disable) any of those users.

1. Click the [Manage Users](#) link on the main menu.

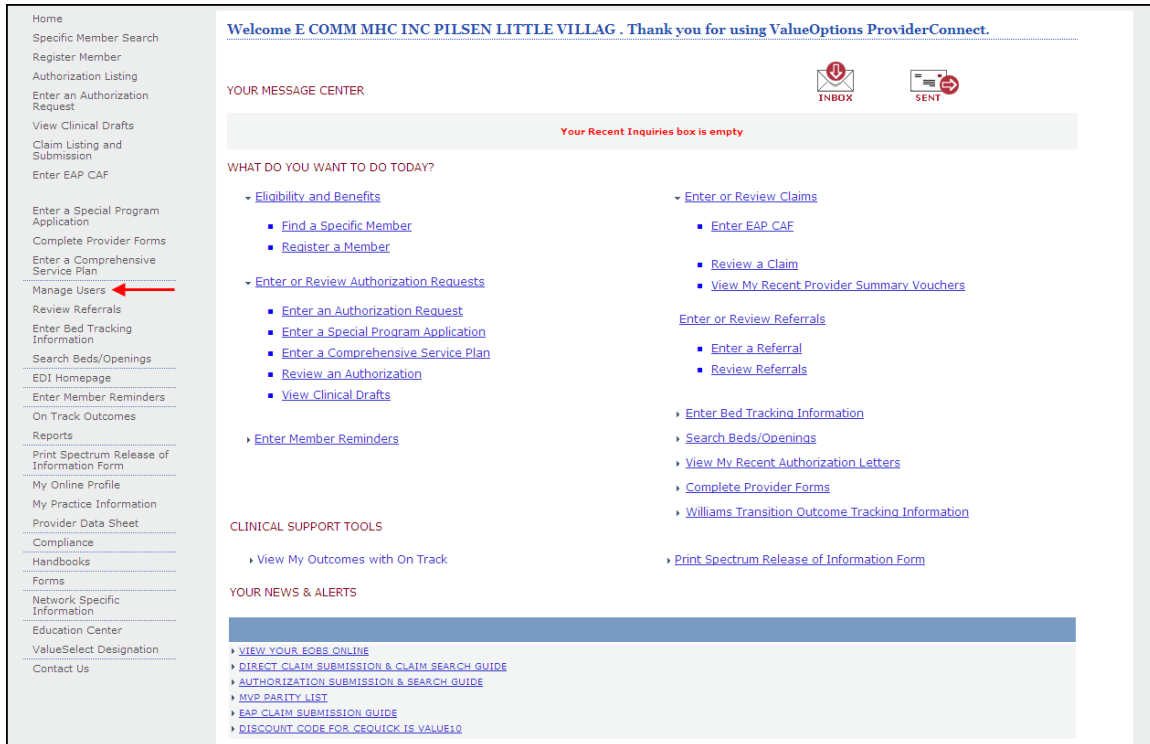


Figure 129: Manage Users Link

The Manage Users page displays.

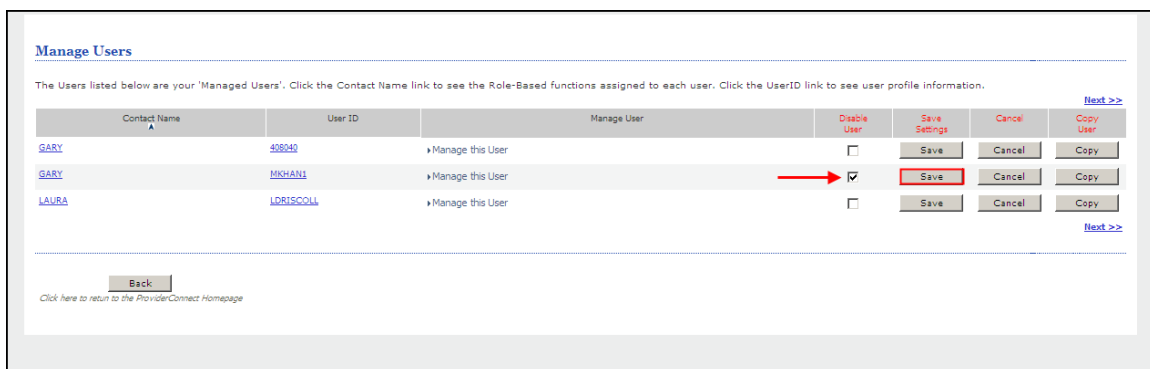


Figure 130: Deactivate User

2. Select the **Disable User** checkbox for the managed user you wish to deactivate.
3. Click **Save**.

The following message displays the next time the deactivated user attempts to log in:
“Your account has been disabled. Please contact e-Support Services by email at e-support.Services@beaconhealthoptions.com or by phone 888-247-9311 to activate your account.”

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Glossary of Terms

<i>Term</i>	<i>Definition</i>
ABA	Applied Behavioral Analysis. The process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement of behavior.
CAF	Case Activity Form. Network providers authorized to perform EAP Services can submit their one-page version of this form via ProviderConnect.
Clinical Draft	An authorization request that a provider has created and saved but not submitted. Creators of clinical drafts can authorize other users to update and/or submit saved drafts.
COB	Coordination of Benefits. A provision which requires that when a member is covered by two or more group health plans, payment will be divided between them so the combined coverage will pay up to 100% of eligible expenses.
Compliance	This part of ProviderConnect contains regulatory and HIPAA information, resources, and technical assistance contact information.
Comprehensive Service Plan	Refers to the Comprehensive Service Plan workflow for parent code ILL.
CSR	Customer Service Representative. A Beacon staff member who responds to provider inquiries.
DOB	Date of Birth. Refers to a member's birth date.
EDI	Electronic Data Interchange. The structured transmission of data between organizations by electronic means. Used to transfer electronic documents or business data from one computer system to another computer system.
FDS	Facility Data Sheet. The FDS is Beacon's online facility and organizational provider re-credentialing application. (Also see PDS)
HIPAA	Health Insurance Portability and Accountability Act of 1996. The primary goal of this law is to help employees take their health benefits with them upon a move from one employer to another. The law also includes an Administrative Simplification provision with the goals of improving: <ul style="list-style-type: none"> • Efficiency of the health care system by encouraging the use of electronic information systems. • Privacy and security protections for individually identifiable health information.
Individual Care Plan	Refers to the Individual Care Plan workflow for parent code MRLD.
ITR	Inpatient Treatment Report. The ITR and ITR2 forms are both used to enter IP/HLOC requests for services.

Term	Definition
Member Reminders	Appointment and/or medication reminders entered for a member.
OnTrack Outcomes	The Beacon Health Options <i>OnTrack</i> program is a client-centered outcomes-informed care program that provides clinicians with state-of-the-art easy to use tools that promote improved client outcomes.
ORF1	Outpatient Review Form 1. A short form used for routine OP requests for services requiring limited clinical information.
ORF2	Outpatient Review Form 2. A longer form that captures more detailed clinical information via both required and optional data fields.
PDS	Provider Data Sheet. The PDS is Beacon's online provider re-credentialing application.
Performance Report	This part of ProviderConnect allows information about a provider to be entered and saved. Displays in the form of a performance report card.
RFS	Request for Services. Providers can electronically submit requests for services for Outpatient, Inpatient, and Medication Management services using the Enter an Authorization/Notification Request function.
Special Program Application	Refers to the Special Program Application workflow for parent code ILL.
ValueSelect Designation	A designation that recognizes network outpatient providers for engaging in activities that promote clinical effectiveness, member access to services, member satisfaction, and administrative efficiency.
VSP	Value Service Provider. Designation that is reserved for top-of-the-line Beacon providers.
Wellness Recovery Treatment Plan	Refers to the Wellness Recovery Treatment Plan workflow for parent code BHK.

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Warn & restrict access to ProviderConnect
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