beacon health options

Online Provider Services Account Request Form

Required fields are marked with an asterisk. *
Fax completed form to 855-750-9862 or
email to CTCHILDANDFAMILY@beaconhealthoptions.com

The Account Request Form is only for activating online User Access to ProviderConnect for CT Child and Family Voluntary Services. Voluntary Service Providers will utilize this account ID and password to view authorizations for Non-Medicaid Voluntary Service members. For ProviderConnect online access to complete authorizations for HUSKY Medicaid members, providers should utilize the CT BHP Online Account Request Form: http://www.ctbhp.com/providers/forms/Account_Request_Form.pdf

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***Provider, Group Practice or Facility Name**

_____

***Voluntary Provider ID (IFCS#), NPI or Tax ID**

_____

***Address**

_____

***City** ***State** ***Zip Code**

_____

***User's Name – Please print clearly**

_____

***User's E-mail address – Please print clearly**

***Telephone Number:** _____ **Fax Number:** _____

Agreement Terms:

A. **All submitted information must be true, accurate and complete. I/We understand that payment of any claim submitted in falsification or concealment of a material fact may be prosecuted under any applicable state and/or federal laws.**

B. **The Submitter agrees to comply with any laws, rules and regulations governing the Beacon Health Options Online Provider Services/EDI program.**

C. **The Provider agrees to accept, as payment in full, the amounts paid in accordance with the fee schedules provided for under previously established agreements with Beacon Health Options.**

D. **This is to certify that an exact copy of any claim files submitted via the Beacon Health Options ETS system or Online Provider Services program will be stored in an electronic medium and held by the originator for a period of 90 days or until the submission has been finalized as to reimbursement or denial of payment, whichever comes first.**

This is to certify that the following is true:

☐ **I am a provider OR** ☐ **I am office staff of a Provider and am authorized to sign on their behalf.**

Signatures:

_____

Legal name of Organization **Title of individual signing for organization**

_____

***Name of Individual Signing for Organization** ***Authorizing Signature** ***Date**