Value Options – Multiple user ids

Thank you for choosing Electronic Network Systems Clearinghouse, a division of Optum, to submit your Claims/ERAs. The following instructions have been created in order to help you quickly enroll with the payer you have chosen. Please be advised that we make every effort to keep these forms up to date.

Please submit the attached forms to Optum via one of the following methods:

> Fax: **877-630-2064**
> Email: **enrollments@optum.com**

Optum requests all agreements be returned to the above mentioned fax number or email address. We will attach your agreements to your account in our system for tracking purposes.

Attached you will find the "OPTUM Provider Setup Form". Please complete this form and return it to Optum with a copy of the agreement. This information, **along with your 8 digit ENS/Optum user id on all correspondence**, will allow Optum to setup all provider information linked with your group.

If you have any questions, please contact the Enrollment Department at 866-367-9778, Option 1.

Enrollment Agreement Instructions:

To Enroll in Value Options – plan specific, please select from the payer list:
- Value Options Commercial (Payer ID 00813)
- Value Options CO Medicaid (Payer ID 00815)
- Value Options MA Behavioral Health Partnership Medicaid (Payer ID 00816)
- Value Options PA Medicaid (Payer ID 00817)
- Value Options TX North Star (Payer ID 00818)
- Value Options MD Medicaid (Payer ID 77063)

Providers must be enrolled and have a provider ID assigned prior to completing this agreement. If you do not know your Vendor Number, please contact your local Network Rep (See page 3 of the Value Options form) or contact the National Network at 800-397-1630. If you participate in more than one plan, only one agreement is needed for each provider. This form has been modified so that it can be typed into. The clearinghouse information has been prepopulated with Gateway EDI's information for your convenience. Also page 3 of the form contains instructions to help complete this form.

Once complete, please return this form with the OPTUM Provider Setup Form to the Optum Enrollment Department using one of the methods listed above. Please be sure to add the payer id that you selected on the Optum Provider Setup Form. The Enrollments Department will complete the setup with the payer on your behalf.

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Required fields are marked with an asterisk. *
Fax pages 1 & 2 of completed form to 866-698-6032.
Questions on this form? Read instructions on page 3.

Special Setup: (See page 3)
☐ Additional Login Account
☐ New Combined Account
☐ Existing Combined Account:
Login ID: _____

*Provider, Practice or Facility Name

_____

*ValueOptions assigned Provider ID. If not known, please see page 3

*NATIONAL PROVIDER IDENTIFIER # (NPI)

*Provider, Practice or Facility Tax IDs to be associated to this online account. If more than one, please list all.

*Address

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

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

*Please check which Online Provider Services options you would like to have access to:

☐ **Electronic Batch Claims Submission**
   (837 HIPAA format)
☐ **Online Claims Adjustment**

Direct Online Functions:
☐ **Direct Claims Submission**
☐ **Online Claims Adjustment**

Automatically included:
☒ **Eligibility Inquiry** ☒ **Claim Status Inquiry**
☒ **Authorization Inquiry & Submission**
☒ **Provider Summary Vouchers/EOBs**

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

Depending on the state in which you are practicing, you may need multiple accounts created to ensure the claims are processed accurately (i.e. Medicaid vs. Commercial). Therefore, to help us in setting up your account(s) correctly, if you are located in…

Colorado, will you be submitting CO Medicaid clients?	☐ Yes	☐ No, Commercial Only	☐ Both	
Illinois, will you be submitting Illinois Mental Health Collaborative or ICG clients?	☐ Yes	☐ No, Commercial Only	☐ Both	
If yes, will you be submitting Batch Registration Files?	☐ Yes	☐ No		
Kansas, will you be submitting either KS Medicaid Claims or AAPS Block Grant clients?	☐ Yes	☐ No, Commercial Only	☐ Both	
Maryland, will you be submitting MD MHA clients?	☐ Yes	☐ No, Commercial Only	☐ Both	
Massachusetts, will you be submitting MBHP clients?	☐ Yes	☐ No, Commercial Only	☐ Both	
Pennsylvania, will you be submitting SWPA Medicaid clients?	☐ Yes	☐ No, Commercial Only	☐ Both	
Pennsylvania, will you be submitting for the Non-HealthChoices Mental Health Program?	☐ Yes	☐ No Counties: _____		
Texas, will you be submitting TX NorthSTAR clients?	☐ Yes	☐ No, Commercial Only	☐ Both	

_____@_____
*Provider's Contact e-mail address – Please print

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

*Contact Name at Provider's Office

Online Provider Services
Account Request Form

Required fields are marked with an asterisk. *
Fax pages 1 & 2 of completed form to 866-698-6032.
Questions on this form? Read instructions on page 3.

Agreement Terms:

A. The undersigned submitter authorizes ValueOptions to receive and process claims or batch registration submissions via the ValueOptions Electronic Transport System (ETS) or ValueOptions Online Provider Services Program on his/her/its behalf in accordance with the applicable regulations.

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

C. The Submitter agrees to comply with any laws, rules and regulations governing the ValueOptions Online Provider Services/EDI program.

D. The Provider agrees to accept, as payment in full, the amounts paid in accordance with the fee schedules provided for under previously established agreements with ValueOptions.

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

*This is to certify that the following is true:

_____I am a provider
        OR
_____I am office staff of a Provider, and am authorized to sign on their behalf.

Signatures:

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

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

ValueOptions, Inc / EDI Helpdesk / PO Box 1287, Latham, NY 12110/Phone#: 888-247-9311
Forms that are incomplete, incorrect or illegible may delay or prevent proper processing.

**Online Provider Services
Account Request Form**

| **Required fields are marked with an asterisk.** *
Fax pages 1 & 2 of completed form to 866-698-6032.
Questions on this form? Read instructions on page 3. |

Instructions for Account Request Form

The Account Request Form is only for activating online access on ValueOptions ProviderConnect website. If you need to update your address, tax ID or NPI information, you will need to contact our ProviderRelations area at 800-397-1630. Please do not make additional notations on the Account Request Form unless advised to do so by these instructions or by the EDI Helpdesk.

For guides on Direct Claim Submission and Authorization Submission, visit the Compliance page at:
http://www.valueoptions.com/providers/ProCompliance.htm

Additional Login Account?
If a ProviderConnect account already exists for the provider or facility, and an office staff member needs their own unique ID/password, you can check this box. If this secondary account needs to be disabled or deleted for any reason, it will be the provider's responsibility to contact the EDI Helpdesk immediately.

New Combined Account:
Only check this box if you are registering multiple provider numbers, you want them accessible from a single user ID and password, and if you currently do not have a login ID for ProviderConnect. In the area for Provider Number, you can write "See Attached List," and include an additional list containing the provider's name, ValueOptions provider #, NPI, and tax ID. This information must be complete and accurate.

Existing Combined Account:
Only check this box if you currently have a Combined account login ID for ProviderConnect, and you want to include an additional provider number to be accessible from this account. Please write your existing login ID on the blank line. Make sure you put the new provider number in the appropriate field, or send a list as described above.

Provider ID number:
You can retrieve your ValueOptions assigned provider number by reviewing any Provider Summary Vouchers/EOBs you have previously received; the Provider # will be present at the beginning of each claim. Or, depending on what state and type of claims you will be submitting, the following service centers will be able to best assist you:

> For all commercial accounts or states not listed below: 800-397-1630
> Colorado Medicaid: 800-397-1630
> Illinois Mental Health Collaborative or ICG: 800-397-1630
> Kansas Medicaid or AAPS Block Grant: 800-397-1630
> Maryland MHA: 800-888-1965
> Massachusetts MBHP: 800-495-0086 (If submitting for both Commercial and MBHP clients, please provide both provider numbers)
> Pennsylvania SWPA Medicaid or Non-HealthChoices Mental Health Program: 800-397-1630
> Texas NorthSTAR: 800-397-1630

Batch vs. Direct Claim Submission:
Direct Claim Submission: If you are a smaller practice, or happen to have a low volume of Professional claims (normally submitted on a HCFA-1500 or CMS-1500), Single Claim Submission may be best and easiest. With this option, you can submit each claim directly on the website, the member and provider information are verified, and you receive a claim number right away.
Batch Claim Submission: If you have to submit Institutional claims (submitted on a UB-92 or UB-04 form), and/or if you have a larger volume of Professional Claims, you can select Batch Claim submission. With this feature, you will create your claims using either our EDI Claims Link Software, or any practice management software that can create an 837 HIPAA file. You will then upload a batch file via our website for processing. Claim numbers are usually available in about 1 business day. All new accounts are set up in test mode. A successful test batch must be submitted, and the EDI Helpdesk contacted to switch to production mode.
Claim Adjustment: The ProviderConnect Online Adjustment Module allows users to electronically submit changes (adjustments) to previously processed claims. This feature allows users to correct claims where the original result of the claim's processing is not the correct outcome for the services rendered or where information was submitted incorrectly on the original claim.

Commercial and Medicaid Claims:
We may need to create more than one online account for you if you need to submit both commercial and Medicaid claims.
If you only select commercial or Medicaid for now, and you need to add the other in the future, please contact the EDI Helpdesk and we can make the appropriate updates for you. **If no option is checked, the default will be Commercial Only**.

Forms that are incomplete, incorrect or illegible may delay or prevent proper processing.

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Online Provider Services
Intermediary Authorization Form

INSTRUCTIONS:
This form should be completed by providers who contract with a third party to submit claims. If the Billing Intermediary will submit claims for multiple providers, an Account Request Form and an Intermediary Authorization Form is required for each provider. Forms that are incomplete, incorrect or illegible may delay or prevent proper processing.

Billing Agent/Clearinghouse/Intermediary Information

*Billing Intermediary Name

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

*Contact name at billing intermediary

*Email address at billing intermediary

*Phone number at intermediary

Provider Information:

*Provider Name

*Provider NPI number

*ValueOptions assigned provider ID number

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

☐ Electronic Batch Claims Submission   **Direct Online Functions:**
   (837 HIPAA format)   ☐ Direct Claims Submission
☐ Online Claims Adjustment   ☐ Online Claims Adjustment

Automatically included:
☒ Eligibility Inquiry ☒ Claim Status Inquiry
☒ Authorization Inquiry & Submission
☒ Provider Summary Vouchers/EOBs

Agreement Terms:
A. The undersigned Provider authorizes the above Billing Intermediary to submit claims to ValueOptions on his/her/its behalf in accordance with any applicable regulations.
B. The provider warrants that he/she/it has entered into a written agreement with above named Billing Intermediary. The provider understands and agrees that its use of this Billing Intermediary does not in any manner relieve the provider of full responsibility and liability for any violations of the laws, regulations and rules which govern the ValueOptions EDI program.
C. The provider accepts full liability for all actions of the above named Billing Intermediary within its actual or apparent authority to act on behalf of the provider, notwithstanding any contrary provisions in the agreement between the provider and the Billing Intermediary. In the case of any violations of applicable laws, rules and regulations governing the ValueOptions EDI program, which arise out of the actions of the Billing Intermediary, the provider accepts full liability as though these actions were the provider's own actions.
D. The provider agrees to notify ValueOptions in writing at least ten (10) days prior to the effective date of the revocation of this Intermediary Authorization Form. In such event, the provider's liability for the acts of the Billing Intermediary will continue until the tenth day after the receipt of such notification or the effective date of the revocation, whichever is later.

Signatures:

*Billing Intermediary's Signature

Date

*Provider or provider's staff signature

Date

OPTUM Provider Setup Form
Value Options Payer ID:_____

Please complete the requested information below. This information will be used to ensure your agreements are setup and processed in the most efficient manner. This form is for Optum use only and will not be forwarded on to the payer with your enrollment agreements.

Optum user ID:	
Contact Name:	
Group Name:	
Group Billing TIN:	
Group Billing NPI:	
Group Legacy ID:	

Please list all providers for this Payer below:

Provider Name	Individual PTAN or Legacy ID (if applicable)	Individual NPI	Payer Name