ProviderConnect User Guide
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### Revision History

Click on the link for the revision in which you are interested. Although every effort is made to keep the links current, users should consult the Table of Contents if a particular link does not work.

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1 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

Course and User Guide Overview

After successfully completing this course, 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 the National IT Trainers at: ITtrainingrequests@beaconhealthoptions.com

Before You Begin
Be aware of the following before using this guide.

- Screen captures are examples only.
- The workflows presented in this document represent one possible scenario.
  Workflows may vary in practice depending on a particular user’s circumstances.
Accessing ProviderConnect

Log On to ProviderConnect

To log on to ProviderConnect:

1. Access the following URL: [www.beaconhealthoptions.com](http://www.beaconhealthoptions.com)

The Beacon Health Options home page displays.

2. Click on the ValueOptions link. (Located under HELPFUL LINKS.)
3. Click the Providers tab.

The Provider Services page displays.

4. Click the Log In link.
5. Click Log In.
6. Enter your User ID and Password.
7. Click Log In.

---

**Figure 1**: ProviderConnect Login

*Note: ProviderConnect permits submitters belonging to providers with the same NPI# to use a single login to access multiple accounts.*

8. Carefully read the ProviderConnect Use Agreement and then select I Agree.
New User Registration

New users must register in order to access the ProviderConnect application.

1. Click Register.

![Figure 2: New User Registration](image)

The Provider Online Services Registration page displays. Complete the following information.

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

2. Enter the provider’s first and last names in the **First Name** and **Last Name** fields.
3. Enter a contact name in the **Contact Name** field.
4. Enter the provider number in the **Provider ID** field. Contact National Networks at 800.397.1630 to obtain a provider ID number if needed.
   
   **Note:** The provider ID is a six-digit number assigned by Beacon.

5. Enter the provider’s nine-digit Federal ID or Social Security Number in the **Tax ID** field.
6. Enter the provider’s group, facility, or clinic name if applicable.
7. Enter the provider’s primary e-mail address in the **Primary Email Address** field.
   
   **Note:** E-mail addresses must be formatted as **abc@xyz.com**.

8. Enter the same e-mail address in the **Verify Primary Email Address** field.
9. Enter the provider’s secondary e-mail address in the **Secondary Email Address** field.
10. Enter a ten-digit phone number without dashes in the **Phone Number** field.
11. Enter a ten-digit number without dashes in the **Fax Number** field.
12. Enter a password in the Select a Password field. (See: Password Change Rules)
   - Passwords must contain at least:
     - One number (0-9) and,
     - One upper case letter (A-Z) and,
     - One lower case letter (a-z) and,
     - One of the following special characters:
       - !
       - #
       - $
       - ~
       - *
       - %
       - &
       - ,
       - ( 
       - )
       - *
       - +
       - ,
       - .
13. Enter the same password in the Confirm New Password field.
14. Create a security question in the Create a Security Question field.
15. Enter the answer to the question in the Answer to Security Question field.
16. Select the Claims Submission checkbox if applicable. (Go to: Account Request Form)
17. Click Next.

The Use Agreement page displays.

18. Select I Agree. (This completes the registration process.)

**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.

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

  **Note:** Passwords cannot contain spaces and are case-sensitive.
**Account Request Form**

Upon clicking **Claims Submission** and then **Next**, the Use Agreement page displays. Upon agreeing to the terms of use, the Account Request Form displays pre-populated with the provider name; provider ID; NPI# (if available); Tax ID (if entered); and group, facility, or clinic name (if entered).

The following fields display on this form.

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

- Provider Name (pre-populated)
- Provider ID (pre-populated)
- NPI# (pre-populated if available)
- Tax ID (pre-populated if entered)
- 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.
- 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 the Click here to sign this document electronically link. 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.)

Note: 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.


3. Carefully read the information on this page.
4. Click on the Yes link 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. The 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

Providers can access information without logging on to ProviderConnect. Links available on the Providers page include:

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<th>Description</th>
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<tr>
<td>Providers’ Home</td>
<td>Enables users to return to the Providers home page.</td>
</tr>
<tr>
<td>Provider Handbook</td>
<td>Provides users with information on Beacon’s policies and procedures.</td>
</tr>
<tr>
<td>Forms</td>
<td>Provides users with administrative, clinical, and EAP forms specific to Beacon Health Options.</td>
</tr>
<tr>
<td>Education Center</td>
<td>Provides articles, workshops, training tools, and access to external web sites (e.g., Achieve Solutions).</td>
</tr>
<tr>
<td>Compliance</td>
<td>Provides information specific to federal and state program requirements for maintaining HIPAA-compliant claims submission.</td>
</tr>
<tr>
<td>Network-Specific</td>
<td>Provides program-specific handbooks, forms, and other details that are unique to a specific network.</td>
</tr>
<tr>
<td>News</td>
<td>Provides internal and external articles and updates.</td>
</tr>
<tr>
<td>Provider Contact</td>
<td>Provides information for Beacon’s customer service web sites and technical support.</td>
</tr>
<tr>
<td>Practice Profile</td>
<td>Provides access to provider profiles. <em>(Note: Must enter a User ID and Password to review secure information.)</em></td>
</tr>
<tr>
<td>How-To Resources</td>
<td>Provides access to video tutorials that help providers navigate and perform the tasks needed to successfully do business with Beacon Health Options.</td>
</tr>
<tr>
<td>ProviderConnect Helpful Resources</td>
<td>Provides access to helpful resources such as user guides, claims resources, forms, HIPAA resources, and webinars.</td>
</tr>
</tbody>
</table>
3 ProviderConnect Navigation

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

Figure 4: ProviderConnect Home Page Example
Main Menu

A user can access a specific section by clicking the appropriate link on the 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** link allows the user to link or unlink accounts as necessary.

- 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 web site to retrieve Explanations of Benefits (EOBs) and receive any payments that were submitted electronically.

  **Note:** Provider must be assigned the appropriate role.

- Enter or Review Authorization Requests
  - 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 navigation bar options are alphabetized here for ease of reference.

- Authorization Listing
- 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/Openings
- 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.”

Note: All messages in the provider’s Inbox, including messages from Beacon, will be available for viewing until the provider deletes them.

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

Note: All messages in the provider’s Sent Messages, including inquiries and replies sent to Beacon, will be available for viewing until the provider deletes them.
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 particular 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.)

**Note:** 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 particular 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.

**Note:** 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 functionality, and
- The provider has not disabled communication with that member, and
- The member has not disabled communication with that provider.

Upon clicking the Send Message to Member link, 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 particular 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.
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.

Note: 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.

Figure 5: 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.

![Submit Batch File - Step 1 of 4](image)

Figure 6: 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.

![Submit Batch Claim - Step 2 of 4](image)

Figure 7: Step 2 of 4

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

1. Click Browse.
2. Search for the batch file.
3. Select the batch file.
4. Click **Open**.
5. Click **Upload**. The batch file transfer will begin.

**Note:** Some restrictions apply to the files, such as files must be only text or zip files, they must be at least 50 bytes in size, and they 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.
**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](image)

Figure 10: Search Files on EDI Transactions

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

4. Click **Search**.

![Search File Submissions](image)

Figure 11: Search File Submissions

The Batch Claim Submissions Search Results page displays.
5. Click on the Tracking # link for the file.

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 Details

**Submission Information - Current as of 06/06/2010 (08:18:15 AM) EST**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submission Number</td>
<td>0808213599</td>
</tr>
<tr>
<td>Form Type</td>
<td>0378</td>
</tr>
<tr>
<td>Upload Date &amp; Time</td>
<td>06/21/2009 10:00:01 AM EST</td>
</tr>
<tr>
<td>Process Date &amp; Time</td>
<td>06/21/2009 10:00:07 AM EST</td>
</tr>
<tr>
<td>Entry Location</td>
<td>None</td>
</tr>
<tr>
<td>File Status</td>
<td>Failed</td>
</tr>
<tr>
<td>Original File</td>
<td></td>
</tr>
<tr>
<td>File Name</td>
<td>81191300.txt</td>
</tr>
<tr>
<td>File Size</td>
<td>1199 Byte(s)</td>
</tr>
<tr>
<td>Verification Object</td>
<td>ETHES4AA767pg1</td>
</tr>
<tr>
<td>Export File Name</td>
<td></td>
</tr>
<tr>
<td>Queue Position</td>
<td>0 of 488</td>
</tr>
<tr>
<td>Resubmission Data/Time</td>
<td>Resubmitted by</td>
</tr>
<tr>
<td>Resubmission Status</td>
<td>Resubmitted</td>
</tr>
</tbody>
</table>

**Error List**

1. Invalid data; The Authorization Information field (A2) does not match your ValueOptions ESI Submitter ID setting.
   - Additional Information: No additional information is available. Please contact Support Services at 888-247-3333 with any further questions.

2. Invalid data; The Security Information field (A4) does not match your ValueOptions ESI Password setting.
   - Additional Information: No additional information is available. Please contact Support Services at 888-247-3333 with any further questions.

3. Invalid data; The SMTP ID Code must be 36 numeric characters. 000007 is invalid.
   - Additional Information: Error occurred in the Billing Provider Information for [JESERA, ARCTHY].

4. 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 [JESERA, ARCTHY].

5. 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 [JESERA, ARCTHY].

6. Invalid data; The SMTP ID Code must be 36 numeric characters. 000000 is invalid.
   - Additional Information: Error occurred in the Billing Provider Information for [JESERA, ARCTHY].

7. 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 [JESERA, ARCTHY].

8. Invalid data; The SMTP ID Code must be 36 numeric characters. 000001 is invalid.
   - Additional Information: Error occurred in the Billing Provider Information for [JESERA, ARCTHY].

9. Invalid data; The Service Provider ID field is required.
   - Additional Information: Error occurred in the Billing Provider Information for [JESERA, ARCTHY].

**Additional Information**

- The file is over 90 days old and has been archived. Please contact e-support services with questions or concerns.

**Figure 13: 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.

Figure 14: Previous Claims File Batch Submissions
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](image)

**Previous Claims File Batch Submissions**

<table>
<thead>
<tr>
<th>Submission</th>
<th>Result</th>
<th>Date Received</th>
<th>Form #</th>
</tr>
</thead>
<tbody>
<tr>
<td>120900600</td>
<td>Failed Validation</td>
<td>Tue Mar 13 15:00 EST 2006</td>
<td>BAT_CM05</td>
</tr>
<tr>
<td>120800600</td>
<td>Passed Validation</td>
<td>Wed Aug 27 19:28:37 EST 2006</td>
<td>BAT_CM06</td>
</tr>
<tr>
<td>120900600</td>
<td>Failed Validation</td>
<td>Wed Aug 27 11:40:10 EST 2006</td>
<td>BAT_CM07</td>
</tr>
<tr>
<td>120900600</td>
<td>Passed Validation</td>
<td>Wed Aug 27 11:50:10 EST 2006</td>
<td>BAT_CM08</td>
</tr>
<tr>
<td>120900600</td>
<td>Passed Validation</td>
<td>Tue Aug 27 14:57:50 EST 2006</td>
<td>BAT_CM09</td>
</tr>
<tr>
<td>120900600</td>
<td>Passed Validation</td>
<td>Tue Aug 27 14:58:10 EST 2006</td>
<td>BAT_CM10</td>
</tr>
</tbody>
</table>

**Incoming Files**

<table>
<thead>
<tr>
<th>File Name</th>
<th>Date Filed</th>
<th>File Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>120900600</td>
<td>Wed Jan 13 14:56 EST 2006</td>
<td>8732</td>
</tr>
<tr>
<td>120900600</td>
<td>Wed Jan 14 14:50 EST 2006</td>
<td>1150</td>
</tr>
<tr>
<td>120900600</td>
<td>Wed Jan 14 14:50 EST 2006</td>
<td>4213</td>
</tr>
<tr>
<td>120900600</td>
<td>Wed Jan 14 14:50 EST 2006</td>
<td>4213</td>
</tr>
<tr>
<td>120900600</td>
<td>Wed Jan 14 14:50 EST 2006</td>
<td>4213</td>
</tr>
<tr>
<td>120900600</td>
<td>Wed Jan 14 14:50 EST 2006</td>
<td>4213</td>
</tr>
<tr>
<td>120900600</td>
<td>Wed Jan 14 14:50 EST 2006</td>
<td>4213</td>
</tr>
<tr>
<td>120900600</td>
<td>Wed Jan 14 14:50 EST 2006</td>
<td>4213</td>
</tr>
<tr>
<td>120900600</td>
<td>Wed Jan 14 14:50 EST 2006</td>
<td>4213</td>
</tr>
</tbody>
</table>

**Figure 15: Incoming Files**

1. **Click on the File Name link.**

   The View Incoming Files page displays.

2. **Click on the File Name link 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**.
The Download File page displays.

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

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

- Try to [download](#) the file again.
- [Download](#) the file directly. (Right Click on the link and select "Save As...")
- Return to the [Download](#) page.
6 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 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.

Figure 19: Search Member Eligibility & Benefits
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 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

**Demographics Tab**

The Demographics page 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.

![Demographics Tab](image.png)

**Figure 20: Demographics Tab**
Enrollment History Tab

Member enrollment and eligibility information are located on the Enrollment History page. The following information can be found in the Member Detail section of this page.

<table>
<thead>
<tr>
<th>Subscriber ID</th>
<th>Group #</th>
<th>Fund</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID</td>
<td>Group Name</td>
<td>Benefit Package</td>
<td>Date Changed</td>
</tr>
<tr>
<td>Member Name</td>
<td>Account #</td>
<td>Effective Date</td>
<td></td>
</tr>
</tbody>
</table>

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 selected member
- View Member Claims – Displays information about the selected 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

**Note:** The same buttons are located on the next three Member tabs as well.

![Figure 21: Enrollment History Tab](image-url)
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.

Figure 22: COB Tab

Benefits Tab

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

Figure 23: Benefits Tab

Additional Information Tab

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

Figure 24: Additional Information Tab
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 the Search button.

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

View an Authorization Letter

To view an authorization letter:

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

<table>
<thead>
<tr>
<th>Authorization</th>
<th>Member ID</th>
<th>Member Name</th>
<th>DOB</th>
<th>Provider ID</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>View Letter</td>
<td>Auth # Y</td>
<td>01/14/10</td>
<td>01/15/10</td>
<td>01/20/10</td>
<td>Inpatient</td>
</tr>
</tbody>
</table>

   Figure 25: View Letter Icon

2. Click on the View link to display the authorization letter.

The Authorization Letter displays.
View Member Claims

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

1. Click the View Member Claims button.

   \textit{Note: This button also appears on the Enrollment History, COB, Benefits, and Additional Information pages.}

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

- Provider ID
- Claim #
- Service From/Through

2. Click the Search button.

The Member Claims Results display.

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 # link.
View Empire Claims

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

*Note: This function is 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, and Additional Information 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 #** link.

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, and Benefits 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 # link.

**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.

   *Note: Clicking on the Member ID link re-directs you to the Member Demographics page.*

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

**ABA Assessment**

The Applied Behavioral Analysis (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: Does member have an Autism Spectrum Disorder 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
Attach a Document

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

The following text displays below the Attach a Document section:

ABA Assessment/Treatment Planning by BCBA or Licensed Clinician Request in Hours:
Based on 1 hour increment

- Please indicate how many hours are anticipated for completing the assessment (required)
- Provide details on clinical rationale for testing and for the number of hours required, as well as which the assessment tools are to be used (required)

The provider then completes the standard Diagnosis page. (Refer to the Diagnosis section of the Enter an Authorization Request (RFS) chapter for detailed information.)
View Member Registrations

A user can enter/view member registration information. This will allow 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, and Additional Information 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**.

   **Note:** The **Next** button will be disabled if the claim cannot be processed.

---

**Figure 28: Submit a Claim – Step 1 of 3**

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

**Figure 30: 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 #** link 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 the **Send Inquiry** button.

   **Note:** This button also appears on the Enrollment History, COB, Benefits, and Additional Information 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](image)

**Figure 31:** Customer Service Inquiry

The inquiry will be sent to the Beacon Customer Service Center. A confirmation of the submission and an inquiry number will be displayed.
Authorization Listing

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

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

Upon clicking either Authorization Listing or Review an Authorization, the Search Authorizations page displays.

1. Click **View All** to see all the authorizations for the provider. (The Search Results page displays all the authorizations.)

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

   - 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.)

---

**Figure 32: 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).
Enter an Authorization Request (RFS)

The Enter an Authorization Request function enables users 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 will not be sent if a user does not have an e-mail address on file in the user’s ProviderConnect account/profile record. Also, ProviderConnect will send reminder e-mails for only those RFS drafts that are in a “Saved” status, not an “Expired” or “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, will display to the provider with a read-only history of the authorization request that was submitted by the provider and allow 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 the Enter an Authorization/Notification Request link, the Disclaimer page displays.

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

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 will 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.

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

---

**Outpatient Level of Service**

Pages for either an ORF1 or an ORF2 will display for the Outpatient level of service depending on pre-established authorization parameters.

**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.

**Note:** 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.

Figure 36: Type of Services

3. Enter the member’s diagnosis information. (Refer to the **Diagnosis** section under **Outpatient ORF2** authorization requests.)

Figure 37: 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.

![Figure 38: Current Risks](image)

**Note:** Click on 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**.

![Figure 39: Current Impairments](image)

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 will 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 re-directs 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 will 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.

*Note: Click on the links to display the rating information windows.*

---

**Current Impairments**

In the Current Impairments section:

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

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**ProviderConnect User Guide**

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**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.

**Note:** 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.
Note: 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.

Note: If any of the blue highlighted options are selected, additional fields will 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.

Figure 43: Psychotropic Medications

Note: 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 will 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 re-directs 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.

**Notes:**
- 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.
A page containing several tabs displays.

**Note:** 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.

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

![Current Risks](image)

*Figure 47: Current Risks*
**Current Impairments**

The Current Impairments page displays next.
1. Rate the severity of each of the listed impairments.
2. Click Next.

![Current Impairments](image)

**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.

**Note:** 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.

**Note:** 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.
Figure 49: Treatment History
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.

Figure 50: Psychotropic Medications
**Substance Abuse**

The Substance Abuse page displays next.

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

   ![Substance Abuse Types](image)

   **Figure 51: 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).

   ![Withdrawal Symptoms and Vitals](image)

   **Figure 52: 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 53: 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.)

![Figure 54: 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.

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.
Figure 56: 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 and also decrease the need to contact him/her to obtain additional clinical information.

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.

Notes:
- 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 57: Requested Services Header

A page containing three tabs displays.

Note: 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 will 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 will display.

**Level of Care**
This section contains level of care, type of service, and contact 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 follow-up information is not available.

5. Enter at least one contact name and phone number.

![Figure 58: Level of Care – Contact Information](image-url)
**Diagnosis**
This section comprises the standard DSM-5 Diagnosis page. (Refer to Diagnosis in the Inpatient/HLOC/Specialty Level of Service – ITR Form section of this chapter for detailed information.)

**Medical Implications**
This section contains the following fields and is required if the Primary Medical Diagnostic Category entered on the Diagnosis page is other than None or Unknown.
- Are there any comorbid medical conditions that impact the treatment of the diagnosed MHSU conditions?
- Is the member receiving appropriate medical care for the comorbid medical conditions?

**Metabolic Assessment Tool**
This section contains the BMI functionality from the case management referral follow-up workflow.
1. Enter BMI information.
   - or -
   Select the **BMI not assessed** checkbox.
2. Enter the results of the metabolic syndrome assessment.
3. Enter additional information about the reason for not obtaining BMI if applicable. If the recommendation is to follow up, enter the details about the follow-up when they become available.

![Metabolic Assessment Tool]

Figure 59: 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 will 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 will display.

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
  o Danger to Self Symptom Complex*
    * Required if member’s risk to self is a 2 or 3.
• Member’s Risk to Others
  o 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:
  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
• 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 will automatically be 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 will also be expanded by default. If a particular system complex is required, then the associated Narrative Entry will also be 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 60: 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.)

**Note:** 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

**Note:** 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.

Figure 61: 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 will 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.

![Number of Visits & Expiration Date Pop-up](image)

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 will apply.

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.
10 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 Services

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: Does member have an Autism Spectrum Disorder 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
Supporting documentation is *required* if the answer to the Autism Spectrum Disorder diagnosis question is **Yes**.

Supporting documentation is *not required* if the answer to the Autism Spectrum Disorder diagnosis question is **No**.

Supporting documentation is *not required* if the provider has indicated that the diagnosis was already submitted.

The provider must next answer the following question: **Does member have a co-occurring mental health diagnosis?**

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.”

**Note:** This field is required for concurrent requests for services only.

The following instructions display next.


> “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

**Note:** 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.
- During recent authorization period were there any gaps in treatment?
11

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 the Weekly ABA Measures link. (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.

Figure 64: ABA Maladaptive Behavior & ABA Skills Data Tracking Buttons
Enter ABA Maladaptive Behavior

Clicking the Enter ABA Maladaptive Behavior button re-directs the user to the ABA Maladaptive Behavior page for him/her to enter weekly maladaptive behavior updates for the selected 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 re-directs the user to the ABA Skills page for him/her to enter weekly skills updates for the selected 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 re-directed to the IntelligenceConnect application where he/she can view the ABA Maladaptive Behaviors and ABA Skills Graphical Reports.

**Note:** 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 re-directs 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 re-directs the user to the ABA Maladaptive Behavior page.

Clicking the Enter ABA Skills button re-directs 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.
12 Review an Authorization – EAP CAF

The Review an Authorization Request function enables users 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 the Review an Authorization link, the Search Authorizations page displays.

**Note:** The provider ID will be auto-populated along with the current date.

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 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**.

![Figure 65: Search Authorizations](image-url)
The Authorization Search Results page displays.

**Note:** 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 re-directs the provider to the Authorization Search Results page. (Be aware that only the EAP authorizations that are tied to open EAP cases will be listed.)

![Authorization Search Results](image)

**Figure 66: Authorization Search Results**

4. Click on the Authorization # link adjacent to the appropriate service. **Note:** Member IDs also display as links, but were deleted to protect members’ privacy.

The Auth Summary page displays.

![Auth Summary](image)

**Figure 67: Auth Summary**
5. Click the **Auth Details** tab to view the authorization details.

The Auth Details page displays.

![Auth Details](image)

Figure 68: Auth Details

6. 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.
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 will be bypassed, leaving the date of service blank.

The Select Service Address page displays next.

![Select Service Address](image)

**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**.

![Step 1 of 2](image)

**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**.
The Case Activity & Billing process is complete.

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

- Print Submission Result
- Print Submission
- Download Submission

Figure 73: CAF Results
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. The Save Request function displays as a **Save Request as Draft** button on the Requested Services Header page.

To save a draft of an authorization request:
1. Click on the [Enter an Authorization/Notification Request](#) link.
2. Click Next on the Disclaimer page.
3. Complete the Member ID and Date of Birth fields and click Search.
4. Click Next.
5. Select the service address and click Next.
6. Complete the Requested Services Header page and click Next.

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

**Note:** 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.)

Upon clicking the **Save Request as Draft** button, the following pop-up message displays advising the user how long the draft will be 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 the [View Clinical Drafts](#) link.

Users will be able to 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 will display at the bottom of the page.

**Note:** 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.
**Authorized User**

Creators of clinical drafts have the ability to allow other users to update and/or submit saved drafts via an 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 will be fixed (i.e., static). If only one user was saved, the authorized user ID will display 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 will display the Authorized User field with the updated saved draft information. A read-only pop-up window will display the authorized users associated with a Saved Draft or an Expired Draft (Clinical Request Drafts and Plan Drafts).
14 Enter a Notification

The *Enter a Notification* function enables users to electronically submit a notification using the Global 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**

The 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

**Diagnosis Information**

The diagnosis information is entered next.

- 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** re-directs the user to the Determination Status page.
15  

Recent Provider Summary Vouchers

Users can view recent provider summary vouchers by clicking on the View My Recent Provider Summary Vouchers link.

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 will contain records that match the search criteria. A specific provider summary voucher can be viewed by clicking on the View link.

![Figure 74: Search a Provider Summary Voucher](image)
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 75: 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 will 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 will display.
  - The patient’s date of birth must be filled out, 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 will 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.
17

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 76: 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.
My Online Profile

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

Upon clicking the My Online Profile link, a page containing two sections displays.

- 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.
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.

**Figure 78: 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** link for the appropriate provider.
Figure 79: Provider Search Results

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

Figure 80: Provider Information
2. Enter the necessary Referral Information. Click **Save & Next** to continue.

**Figure 81: Provider Referral Information**
3. Enter the provider’s Practice Information. Click **Save & Next** to continue.
4. Enter the provider’s Education Information. Click **Save & Next** to continue.

![Figure 83: Provider Education Information](image-url)
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.

**Figure 84: 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.

![Figure 85: Malpractice Insurance Information](image-url)

<table>
<thead>
<tr>
<th>6. MALPRACTICE INSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. MALPRACTICE INSURANCE</td>
</tr>
<tr>
<td>Enter your current malpractice carrier. Upload a copy of your current policy certificate and/or declarations page indicating you are the covered doctor, and showing the coverage limits and dates of coverage. If you are unable to upload this document, please fax to 1-866-912-7739.</td>
</tr>
<tr>
<td><img src="image-url" alt="Upload Certificate" /></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>![Edit Carrier]</td>
</tr>
<tr>
<td>![Policy Effective Dates]</td>
</tr>
<tr>
<td>![Delete]</td>
</tr>
<tr>
<td>![No Records Found]</td>
</tr>
<tr>
<td>![Add Insurance Carrier]</td>
</tr>
<tr>
<td>Please provide information on pending and/or settled malpractice claims.</td>
</tr>
<tr>
<td>![Add Claim]</td>
</tr>
<tr>
<td>![No Claims]</td>
</tr>
<tr>
<td>B. MALPRACTICE CLAIMS</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>![Add Claim]</td>
</tr>
<tr>
<td>![No Claims]</td>
</tr>
<tr>
<td>![Add Claim]</td>
</tr>
<tr>
<td>![No Claims]</td>
</tr>
<tr>
<td>C. MALPRACTICE DOCUMENTS</td>
</tr>
<tr>
<td>Documentation is required. If you have malpractice claims pending or settled in the past five (5) years (include any settlements, verdicts, or final dispositions), the documentation must be from an attorney or the entity that issued the judgment. If you are unable to upload the document, please fax to 1-866-912-7739.</td>
</tr>
<tr>
<td>![Upload Malpractice Document]</td>
</tr>
<tr>
<td>![No Documents]</td>
</tr>
</tbody>
</table>
7. Enter the provider’s Work History Information. Click **Save & Next** to continue.

**Figure 86: Work History Information**

8. If applicable, enter the EAP Counselor Information. Click **Save & Next** to continue.

**Figure 87: EAP Counselor Only**
9. If applicable, enter the necessary Disability Provider Network Information. Click **Save & Next** to continue.

**Figure 88: Disability Provider Network Only Information**
10. If applicable, enter the Fitness for Duty Assessment Specialist Network Information (FFD Specialist). Click **Save & Next** to continue.

![FFD Specialist Information](image)

Figure 89: 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.

![Figure 90: Provider Profile Information](image)

**Table: Provider Profile Information**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 impacts your ability to render the professional services which are the subject of the application?</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Insurance Coverage: Has your professional liability insurance coverage ever been denied, canceled, or non-renewed?</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Licenses: Have your medical or professional license(s) in any state ever been revoked, suspended, placed on probation, conditioned status, or limited?</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>DEA: Has your DEA registration certificate ever been suspended, revoked, placed on probation, or limited?</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Hospital Privileges or Participation Status: Have any hospital ever denied you privileges or terminated your participation status?</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Hospital or Provider Network Sanctions: Have you ever been suspended, revoked, or terminated your provider network entity's participation?</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Board Disciplinary Action: Have you ever been the subject of any disciplinary proceedings by any professional association or organization (i.e., state or national professional association; hospital medical or clinical staff)?</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Malpractice Action: Has any malpractice action against you been brought or settled in the past 5 years?</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Medicare Participation: Are you a Medicare participating provider? (Note: N/A = not eligible)</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Medicaid Participation: Are you a Medicaid participating provider? (Note: N/A = not eligible)</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Comments: If you answered yes to questions 1 - 10 or no to question 12, please explain fully in this space.</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>
12. Enter the necessary information for the Substitute for Form W-9 Request for Taxpayer Identification Number. Click **Save & Next** to continue.

![Substitute for Form W-9 Request for Taxpayer Identification Number](image)

**Figure 91: 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 related link can be added to this tab as necessary.**

![Supporting Documentation](image)

**Figure 92: 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 the 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 signing or after my acceptance as a ValueOptions® participating provider; I understand and agree that if ValueOptions® discovers that my application contains any significant misrepresentations, 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 Boards, educational institutions, specialty associations, professional organizations, governmental agencies, and any other person or entity from whom such 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®, Inc. (CVO) and its agents and employees and all those whom ValueOptions®, Inc. and its agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating 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-to-whom member is assigned. 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 to any person to ValueOptions® and its (CVO) all information that they reasonably believe to be necessary to evaluate the qualifications of the proposed or actual provider. This includes personal information that is related to the proposed or actual provider such as: my professional qualifications, disciplinary actions, financial information, personal and professional references, and general information that may be needed to obtain or maintain my participation as a provider of health care services. I also 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 the application; (b) ValueOptions® may not complete the processing of the application until such information is provided by me. In the event that ValueOptions® decides not to agree me as a participating provider, I will accept such determination to the ValueOptions® Provider Appeals Committee ("PAC"); By signing the Attestation/Participation Statement I am not precluded from pursuing any separate rights that I may have under state or federal laws.

**Figure 93: 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 the Proceed to ESIGN Disclosure link.


5. Click on the Yes link 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. The 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.
There are also options on the PDS to Print current page, Print all pages, or Close.
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 the Provider Data Sheet link 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

<table>
<thead>
<tr>
<th>Field/Program Information</th>
<th>Facility Name*</th>
<th>DBA/Trade Name*</th>
<th>Note*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address 1*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing Address 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zip*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone (include area code)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax (include area code)*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Variations in credentials and contracts based on single Tax Identification Numbers (TINs). This recredentialing application applies to the above TIN only.

<table>
<thead>
<tr>
<th>Field/Program Points of Contact</th>
<th>Chief Executive Officer</th>
<th>Phone</th>
<th>Ext</th>
<th>Fax</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Director</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person completing this application</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billing/Claims contact person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracting Contact Person/Title</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field/Program Points of Contact</th>
<th>Chief Medical Officer</th>
<th>Phone</th>
<th>Ext</th>
<th>Fax</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Clinical Officer Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Systems Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>President of the Board of Directors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Website Address of facility      |                        |       |     |     |               |

### C. Corporate Health System (Please complete if Facility/Program is part of a corporate health system).

<table>
<thead>
<tr>
<th>Corporate Name</th>
<th>Contact Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address 1</th>
<th>Mailing Address 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone (include area code)</th>
<th>Fax (include area code)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### D. Facility Description.

**GENERAL HOSPITAL**

### E. Business Classification

- Ownership: [ ] Private [ ] Public [ ] Government Program (State Operated/Federal/State/County/City)
- Type: [ ] For-Profit [ ] Not-for-Profit
- Medicaid Providers only: [ ] Single County Authority [ ] Recertification [ ] Not Applicable
- Medicare Providers only: [ ] Rural Health Center [ ] Federally Qualified Health Center

[Save] [Save & Next]
2. Enter the facility’s License/Accreditation Information, and upload or fax a copy of their current certificate(s). Click **Save & Next** to continue.
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.

---

**Figure 97: 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.
5. 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.

Figure 99: Service Locations and Programs

- Click anywhere in the heading to collapse/expand a specific service location.
- Click the ![delete](icon) icon to delete a specific service location. (If a service location is deleted in error, click the ![undo](icon) icon to undo the deletion.)
- Click the ![verify](icon) icon to verify a specific service location. The following pop-up window displays.
Figure 100: 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.

**Figure 101: 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.

**Figure 102: 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.

---

**SUPPORTING DOCUMENTATION**

Specific contracts may require additional documentation to complete the 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 1-800-612-7795.

[http://www.valenoptions.com/providers/AdminForms.htm](http://www.valenoptions.com/providers/AdminForms.htm)

<table>
<thead>
<tr>
<th>Space</th>
<th>Name</th>
<th>Date/Time Uploaded</th>
<th>Delete</th>
</tr>
</thead>
</table>

---

**Figure 103: 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.

---

**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.

<table>
<thead>
<tr>
<th>Edit</th>
<th>Name</th>
<th>Title</th>
<th>NPI</th>
<th>Status</th>
<th>Delete</th>
</tr>
</thead>
</table>

**Uploaded Roster Files**

<table>
<thead>
<tr>
<th>Name</th>
<th>Document Type</th>
<th>Upload Date</th>
</tr>
</thead>
</table>

---

**Figure 104: 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.)

Figure 105: Participation Information
22 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 the **Update Demographic Information** link. (This link is controlled outside the application. Providers will have access to this link only at certain times.)

The Provider Demographics Summary page displays.

**Note:** A 🎫 icon is available on the various demographics pages that displays additional information upon the provider hovering his/her mouse over the icon.

This page contains the following sections.
- Provider Demographics
- Service Location Information
Figure 106: 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” (겠습니다) 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 107: 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
4. Click Save.

Figure 108: 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.”
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.)

---

**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?** (Yes/No) 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?** (Yes/No) 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 the **Verify** button.

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.

Figure 110: Add a New Federal Tax ID
Figure 111: 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.)
The Performance Report section of ProviderConnect allows provider information to be entered and saved. Upon clicking the Performance Report link, a performance report card displays.

![Figure 112: Performance Report Card](image-url)
24 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.
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 payer 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 45CFR160.310(a), 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 authorized. Members and personnel 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 authorized 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 837P Format
- Behavioral Health Revenue Codes Approved by NURC (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
- 837P 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 (MSWord)
- 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.
- Read the Beacon policies and technical assistance information.
- Click on the links to access additional information.
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.
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.

The Handbook is an extension of the provider agreement and includes policies on doing business with ValueOptions, including policies and procedures for individual providers, affiliates, group practices, programs and facilities. Together, the provider agreement, addenda, and the 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 the handbook should be directed to ValueOptions at (800) 267-1020.

Please click below to launch the Provider handbook and the Provider Handbook Appendices. You will need Adobe® Acrobat 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 1.3 Overview
- Section 2.9 About ValueOptions
- Section 3.1 Contact Information
- Section 4.1.1 Eligibility
- Section 5.3 Electronic Transactions
- Section 6.3 Participating Providers
- Section 7.1 Accreditation & Re-Accreditation
- Section 8.9 Sanctions
- Section 9.25 Appeals of National Accreditation Committee (NAC)/Provider Appeals Committee (PAC) Decisions
- Section 10.9 Office Procedures
- Section 11.9 Services to Members
- Section 12.6 Participating Provider Complaints, Grievances & Appeals
- Section 13.0 Discovery Procedures & E-Commerce Requirements
- Section 14.0 Utilization Management
- Section 15.0 Appeal from Adverse Determinations
- Section 16.0 Quality Management/Quality Improvement

Appendices
- Appendix 1: Handbook Glossary (PDF)
- Appendix 2: List of Forms & Reference Documents
  - Clinical
  - Treatment Guidelines
  - Resource Documents
    - Member Guide (English) (PDF)
    - Member Guide (Spanish) (PDF)
    - AK-ValueOptions Resource Document – Managed Services for ProviderConnect and Electronic Claims (PDF)
    - Provider Summary Medicaid Form Services (PDF)
    - CMS 1500 Claim Form Coverage (1500) (PDF)
    - CMS Claim (PDF)
    - CMS Claim for Coverage (PDF)
    - Clinical Department Forms of Operation (PDF)
  - Claims
    - Administrative
    - Clinical
    - EAP
- Appendix 3: State/Department Program/Network-Specific Procedures and Change Documents
  - Appendix A: Medicare Advantage Specific Provisions (PDF)
  - Appendix B: New York State Specific – Medicare Advantage/Medicaid-Medical Dual Eligible Required Provisions (PA)
  - Appendix C: Medicare Advantage (PDF)
- Appendix D: MVH Handbook (PDF)
- Appendix E: WOS Handbook (PDF)

Provider handbook updates
- Provider handbook updates and Edit 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 any inconsistency between the handbook and the provider contract, ValueOptions reserves the right to interpret such inconsistency. ValueOptions’ interpretation shall be final and binding.

Figure 114: 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
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** link.

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.
Figure 115: 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
28 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.
ValueSelect Designation

Users can access a description of the ValueSelect Network Program by clicking on the ValueSelect Designation link.
The ValueSelect designation recognizes network outpatient providers for engaging in activities that promote clinical effectiveness, member access to services, member satisfaction, and administrative efficiency. ValueSelect 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 ValueSelect designation.

Providers are eligible for ValueSelect 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 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 ValueSelect.

To help providers monitor their performance on ValueSelect and other practice pattern metrics, ValueOptions distributes a semi-annual ValueSelect Provider Performance Report. This report is available to high volume providers through the ProviderConnect web portal.

**Benefits of the ValueSelect Designation**

Outpatient providers who qualify for ValueSelect enjoy a number of benefits:

- **Opportunity for increased referrals** – ValueSelect 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 ValueSelect providers. Providers are able to access this web portal and sign up for self-paced online courses through ProviderConnect. In addition, ValueSelect providers receive invitations to participate in live CME, CEU or professional development (PDH) seminars offered at no charge.
- **Training Discounts** – ValueOptions has partnered with Behavioral Tech, LLC a nationally renowned evidence-based practice (EBP) training firm. Behavioral Tech offers a 10% discount on training for ValueSelect providers.
- **Access to Achieve Solutions** – ValueSelect 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 116: ValueSelect Network Program Description
This section of ProviderConnect contains a summary of contact information. Click on Contact Us to access the Contact Us page.
Contact Us

Interested in joining the network?
Please call (866) 367-1830.

Claims - General Information
If you have questions about claims in general, call (866) 368-3444.

Claims Submission/Address
Reference the address on the provider's identification card, as the address may vary based on payment location.

Member Benefits, Eligibility, and Authorizations
If you have any questions about authorization or benefits, call the (866) number on the back of the member's identification card.

Member Customer Service
To reach Member Customer Service, call the (866) number on the back of the member's identification card.

Provider Supporting Documentation
To send supporting documentation such as medication or insurance coverage sheets, please fax to (866) 612-7715.

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 Help Desk
If you have a technical question about ProviderConnect (website) or EDI Claim Link, please contact the EDI Help Desk at (800) 347-9511 from 8 am - 5 pm Eastern Standard Time.

Fax: (919) 686-6823
Email: support@beaconoptions.com

Mail Address:
ValoConnect
Attn: EDI Helpdesk
PO Box 1287
Lenoir, NC 28688

Credibility Standards
To obtain information pertaining to your network status, contact our National Provider Line at (866) 267-1420 from 8 am - 5 pm Eastern Time.

Fraud and Abuse
Reports of fraud and abuse, or suspicious activity, can be made in writing to:

Mail Address:
ValoConnect
Corporate Headquarters
ATTN: Special Investigations Unit
240 Corporate Boulevard, Suite 200
Norfolk, VA 23502

Clinical Appeals
To request a clinical appeal as a member's behalf, call the (866) number included in the adverse determination letter you received.

Administrative Appeal
To request an administrative appeal, call the (866) number included in the administrative denial letter you received.

Complaints/Grievances
To file a complaint/nuisance, call the (866) 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/Delaying Absences
Contact the Clinical Care Manager with whom you conduct reviews during absences (e.g., vacation, illness, etc.).

Changing Your Provider Profile (i.e., Name, Address)
“Changes of Address” forms can be found at www.valoconnect.com and may be submitted by using one of the following options:

Fax: (866) 612-7770
Email: ValoConnect
Attn: Physician/Provider Maintenance
P.O. Box 4155
Norfolk, VA 23504

NOTE: If a change of address requires an accompanying W-11 form, it is also located at www.valoconnect.com.

Figure 117: Contact Us
Some examples of contact information that can be accessed from this page are:

- Claims – General Information
- Provider Supporting Documentation
- Regional Offices
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

**Note:** 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@valueoptions.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@valueoptions.com. (The managed users can be re-assigned to another super user by the EDI Help Desk. The super user’s account will need to be de-activated 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@valueoptions.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.
The Manage Users page displays.

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.
3. Click the **Copy** button.

The Copy User page displays with some of the fields already pre-populated.

4. Edit any pre-populated information as necessary.

5. 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 122: Manage Users Link](image)

   The Manage Users page displays.

   ![Figure 123: Manage this User](image)

   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:** The logged in super user may not have access to all the function categories.

![Figure 124: Function Categories](image)

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 125: Manage Users Link

   The Manage Users page displays.

   Figure 126: 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@valueoptions.com or by phone 888-247-9311 to activate your account.”
## Glossary of Terms

<table>
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<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABA</td>
<td>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.</td>
</tr>
<tr>
<td>CAF</td>
<td>Case Activity Form. Network providers authorized to perform EAP Services can submit their one-page version of this form via ProviderConnect.</td>
</tr>
<tr>
<td>Clinical Draft</td>
<td>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.</td>
</tr>
<tr>
<td>COB</td>
<td>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.</td>
</tr>
<tr>
<td>Compliance</td>
<td>This part of ProviderConnect contains regulatory and HIPAA information, resources, and technical assistance contact information.</td>
</tr>
<tr>
<td>Comprehensive Service Plan</td>
<td>Refers to the Comprehensive Service Plan workflow for parent code ILL.</td>
</tr>
<tr>
<td>CSR</td>
<td>Customer Service Representative. A Beacon staff member who responds to provider inquiries.</td>
</tr>
<tr>
<td>DOB</td>
<td>Date of Birth. Refers to a member’s birth date.</td>
</tr>
<tr>
<td>EDI</td>
<td>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.</td>
</tr>
<tr>
<td>FDS</td>
<td>Facility Data Sheet. The FDS is Beacon’s online facility and organizational provider re-credentialing application. (Also see PDS)</td>
</tr>
</tbody>
</table>
| 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:  
  - Efficiency of the health care system by encouraging the use of electronic information systems.  
  - Privacy and security protections for individually identifiable health information. |
<p>| 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.                                     |
| Member Reminders | Appointment and/or medication reminders entered for a member.                                                                          |</p>
<table>
<thead>
<tr>
<th><strong>Term</strong></th>
<th><strong>Definition</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>OnTrack Outcomes</td>
<td>The Beacon Health Options <em>OnTrack</em> 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.</td>
</tr>
<tr>
<td>ORF1</td>
<td>Outpatient Review Form 1. A short form used for routine OP requests for services requiring limited clinical information.</td>
</tr>
<tr>
<td>ORF2</td>
<td>Outpatient Review Form 2. A longer form that captures more detailed clinical information via both required and optional data fields.</td>
</tr>
<tr>
<td>PDS</td>
<td>Provider Data Sheet. The PDS is Beacon’s online provider re-credentialing application.</td>
</tr>
<tr>
<td>Performance Report</td>
<td>This part of ProviderConnect allows information about a provider to be entered and saved. Displays in the form of a performance report card.</td>
</tr>
<tr>
<td>RFS</td>
<td>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.</td>
</tr>
<tr>
<td>Special Program Application</td>
<td>Refers to the Special Program Application workflow for parent code ILL.</td>
</tr>
<tr>
<td>ValueSelect Designation</td>
<td>A designation that recognizes network outpatient providers for engaging in activities that promote clinical effectiveness, member access to services, member satisfaction, and administrative efficiency.</td>
</tr>
<tr>
<td>VSP</td>
<td>Value Service Provider. Designation that is reserved for top-of-the-line Beacon providers.</td>
</tr>
<tr>
<td>Wellness Recovery Treatment Plan</td>
<td>Refers to the Wellness Recovery Treatment Plan workflow for parent code BHK.</td>
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