



beacon
health options

***Applied Behavior Analysis (ABA)
Authorization & Billing Process
for MBHP***

September 2015

MBHP is a Beacon Health Options company.

Objectives

- Overview of Billing Codes and Modifier requirement used by MassHealth plans.
- Verifying Member Eligibility.
- Accessing ProviderConnectSM.
- Authorization Procedures & Claim Submission for MBHP.
- Contact Information.
- Questions.

CPT[®] is a registered mark of the American Medical Association.

Overview of Billing Codes and Modifier Requirement

- MassHealth has made the decision to *not* adapt the American Medical Association's (AMA) new CPT codes for ABA services *at this time*
- Four federal HCPCS codes, along with the primary modifier of U2, will be used to denote ABA services

ABA Service Coding

HCPCS Code & Modifier	Service Description	HIPAA Compliant Description	Units
H0031 U2	Assessment and case planning for home services by a BCBA.	Mental Health Assessment by non-physician	1 unit = 15 minutes
H0032 U2	Supervision for home services by a BCBA.	Mental Health Service plan by a non-physician	1 unit = 15 minutes
H2012 U2	Direct instruction by a BCBA – parent training for home services	Behavioral Health day treatment, per hour	1 unit = 1 hour
H2019 U2	Direct instruction by a paraprofessional	Therapeutic Behavioral Health Services, per 15 minutes	1 unit = 15 minutes

Other Information

- The Applied Behavior Analysis Performance Specifications and Medical Necessity Criteria can be found on our website, www.masspartnership.com
- The MBHP Benefit Service Grid, which is also available on our website, www.masspartnership.com, is a useful tool for billing questions such as acceptable place-of-service codes, covered diagnoses, etc.
- For members with third party liability, the primary insurer must always be billed first in order to obtain an EOB. That EOB from the primary insurer indicating that the service was denied or partially paid must then be submitted with the claim to MBHP.



Verifying Member Eligibility

MBHP is a Beacon Health Options company.

MassHealth Eligibility Verification System

- Per provider contracts, MBHP providers are required to verify member eligibility on every date-of-service
- Member eligibility is verified through the MassHealth Eligibility Verification System (EVS), accessed through the MassHealth Virtual Gateway, www.mass.gov (search for “virtual gateway login”)
- Once logged in to the Virtual Gateway, providers can access the Provider Online Service Center (POSC), where EVS is located
- MBHP providers receive a Data Collection Form in the New Provider Welcome Packet. That form must be filled out and mailed/faxed to MassHealth to establish login credentials

MassHealth Virtual Gateway

Executive Office of Health and Human Services - Virtual Gateway



Virtual Gateway



Mass.gov

Welcome to the Virtual Gateway

Login

Username


Password

(Case sensitive)

Login

[Forgot Password](#)

Virtual Gateway Customer Service

Monday through Friday
8:30 am to 5:00 pm
800-421-0938  (Voice)
617-847-6578 (TTY for the deaf and hard of hearing)

Provider Online Service Center

- Homepage of POSC:

The screenshot displays the homepage of the MassHealth Provider Online Service Center. At the top, the page is titled "Health and Human Services" and features the "Mass.gov" logo. A navigation bar includes links for "HOME", "CONSUMERS", "PROVIDERS", "RESEARCHERS", and "GOVERNMENT". The date "September 16, 2015" is shown on the left. Below the navigation bar, there are breadcrumb links: "Mass.Gov Home", "State Agencies", and "State Online Services".

The main content area is titled "MassHealth Provider Online Service Center" and features a central image of two healthcare professionals in blue scrubs. To the right of the image, the text reads: "The Provider Online Service Center gives you the tools to effectively manage your business with MassHealth electronically. Use these services to enroll as a MassHealth provider, manage your profile information, and submit and retrieve transactions. Enter data directly and modify individual transactions (ie. claims submission, eligibility verification, MMQ, Prior Authorization, Pre-Admission Screening, Referrals, and EHR Incentive Program). View your notifications, contracts, reports, metrics, and financial data. Download most MassHealth forms and publications. You will need a Username and password to access many of the services listed on the left. If you are currently a MassHealth provider but do not know your Username and password, please contact the Customer Service Center at 1-800-841-2900." Below this text is a small icon of a person.

On the left side, there is a "Provider Services" menu with the following items: Home, Manage Service Authorizations, Pharmacy Prior Authorization, Manage Correspondence and Reporting, Manage Members, Manage Claims and Payments, Manage Provider Information, Administer Account, Reference Publications, and EHR Incentive Program.

On the right side, there are sections for "News & Updates" (with a link to "MassHealth News & Updates Archive"), "Publications" (with links to "Provider Forms", "Provider Bulletins", "Transmittal Letters", "Provider Manuals", and "MassHealth Proposed Regulations"), and "Related Links" (with links to "EOHHS Pricing Regulations", "Virtual Gateway", "MassHealth", and "Center for Health Information and Analysis").

MassHealth EVS

- Finding Member Eligibility Information
- Click on “Manage Members”
- Then “Eligibility”
- Then “Verify Member Eligibility”

- 
- A screenshot of a web application menu. The menu items are listed vertically, each preceded by a right-pointing chevron (>). The items are: > [Home](#), > [Manage Service Authorizations](#), > [Pharmacy Prior Authorization](#), > [Manage Correspondence and Reporting](#), > [Manage Members](#), > [Manage Claims and Payments](#), > [Manage Provider Information](#), > [Administer Account](#), > [Reference Publications](#), and > [EHR Incentive Program](#). A red arrow points from the text 'Click on "Manage Members"' in the adjacent list to the 'Manage Members' menu item.
- > [Home](#)
 - > [Manage Service Authorizations](#)
 - > [Pharmacy Prior Authorization](#)
 - > [Manage Correspondence and Reporting](#)
 - > [Manage Members](#)
 - > [Manage Claims and Payments](#)
 - > [Manage Provider Information](#)
 - > [Administer Account](#)
 - > [Reference Publications](#)

 - > [EHR Incentive Program](#)

MassHealth EVS *continued...*

- Search criteria:
 - MMIS / SSN / or Name and DOB
 - 1 month maximum date range.
 - Unable to search future dates.

The screenshot shows a web browser window titled "Verify Member Eligibility". The main heading is "Check Member Eligibility". Below this, it says "Please select your Provider" and shows a dropdown menu with the selected value: "1548385057-110031899B-MASSACHUSETTS BEH HL-150 FEDERAL ST FL 3".

Below the provider selection, it says "To identify the member, please enter the Member's ID, or Social Security Number, or the Member's name, date of birth and gender".

The form has several input fields:

- Member ID**: A text input field with a note "found on the Mass Health card".
- OR**: A separator between the Member ID and SSN/Agency ID fields.
- SSN or Other Agency ID**: A text input field.
- OR**: A separator between the SSN/Agency ID and name/date of birth fields.
- Member Last Name**: A text input field.
- Member First Name**: A text input field.
- Date of Birth**: A date input field with a calendar icon.
- Gender**: A dropdown menu.

Below these fields, it says "Please enter 'From Date of Service' or date of service range within a 31 calendar day span:".

The form has two date input fields:

- From Date of Service**: A date input field with a calendar icon, showing "09/16/2015".
- To Date of Service**: A date input field with a calendar icon.

At the bottom right, there is a "Submit" button.

- Click on "Eligibility"

Verify Member Eligibility

Member Information Eligibility

Member Eligibility

Tracking #	Time Stamp
Provider NPI/ID	
Member ID	Date of Birth
Member Name	
SSN or Other Agency ID	
Gender	
Member Address	
Phone Day	
Night	
Cell	
From Date of Service	To Date of Service
Local Office Code	

If you require assistance or support related to this request, please contact Customer Support at 1-800-841-2900

Close Perform Another Eligibility Check

MassHealth EVS *continued...*

- Click on “Date Range” to expand information

Verify Member Eligibility

Member Information | Eligibility

Dates of Eligibility

Click on the Date Range to view Eligibility information for Member ID

Date Range	Eligibility Status
→ 09/16/2015 09/16/2015	MASSHEALTH STANDARD

The information below refers to the **MASSHEALTH STANDARD** coverage for 09/16/2015 to 09/16/2015.

Eligibility Restrictive Messages

Restrictive Messages	246 / 246 EXEMPT FROM COPAY ON PHARMACY SERVICES UNDER 130 CMR 450.130(D).
	186 / 186 EXEMPT FROM COPAY ON NON-PHARMACY SERVICES UNDER 130 CMR 450.130(D).

List of Managed Care Data (if PCC)

Legal Name	Site Name	Site Phone	Date Range
------------	-----------	------------	------------

List of Behavioral Health

Provider Name	NPI	Provider Phone	Date Range
MASSACHUSETTS BEH HLTH PRT	1548385057	(800) 495-0086	09/16/2015 09/16/2015

- Look for MBHP to confirm eligibility



Accessing ProviderConnect

MBHP is a Beacon Health Options company.

Accessing Provider Connect

<https://www.masspartnership.com>



HOME EMERGENCY SERVICES PROGRAM FIND A PROVIDER **PROVIDERCONNECT**  BEHAVIORAL HEALTH PRO

Members and Families Behavioral Health Providers PCC Plan Providers About Contact

*The Massachusetts
Behavioral Health
Partnership (MBHP)*



Logging into ProviderConnect

Please Log In

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

Please log in by entering your User ID and password below.

*User ID

123456

If you do not remember your User ID, please contact our e-Support Help Line.

*Password

●●●●●●●●

[Forgot Your Password?](#)

Log In

Password expires every 90 days, please click link below to be taken to 'Expired Password' page.

[Expired Password](#)

The information and resources provided through the ValueOptions site are provided for informational purposes only. Behavioral health providers utilizing the ValueOptions site ("Providers") are solely responsible for determining the appropriateness and manner of utilizing ValueOptions information and resources in providing services to their patients. No information or resource provided through the ValueOptions site is intended to substitute for the professional judgment of a behavioral health professional. Providers are solely responsible for determining whether use of a resource provided through ValueOptions is consistent with their scope of licensure under applicable laws and ethical standards.

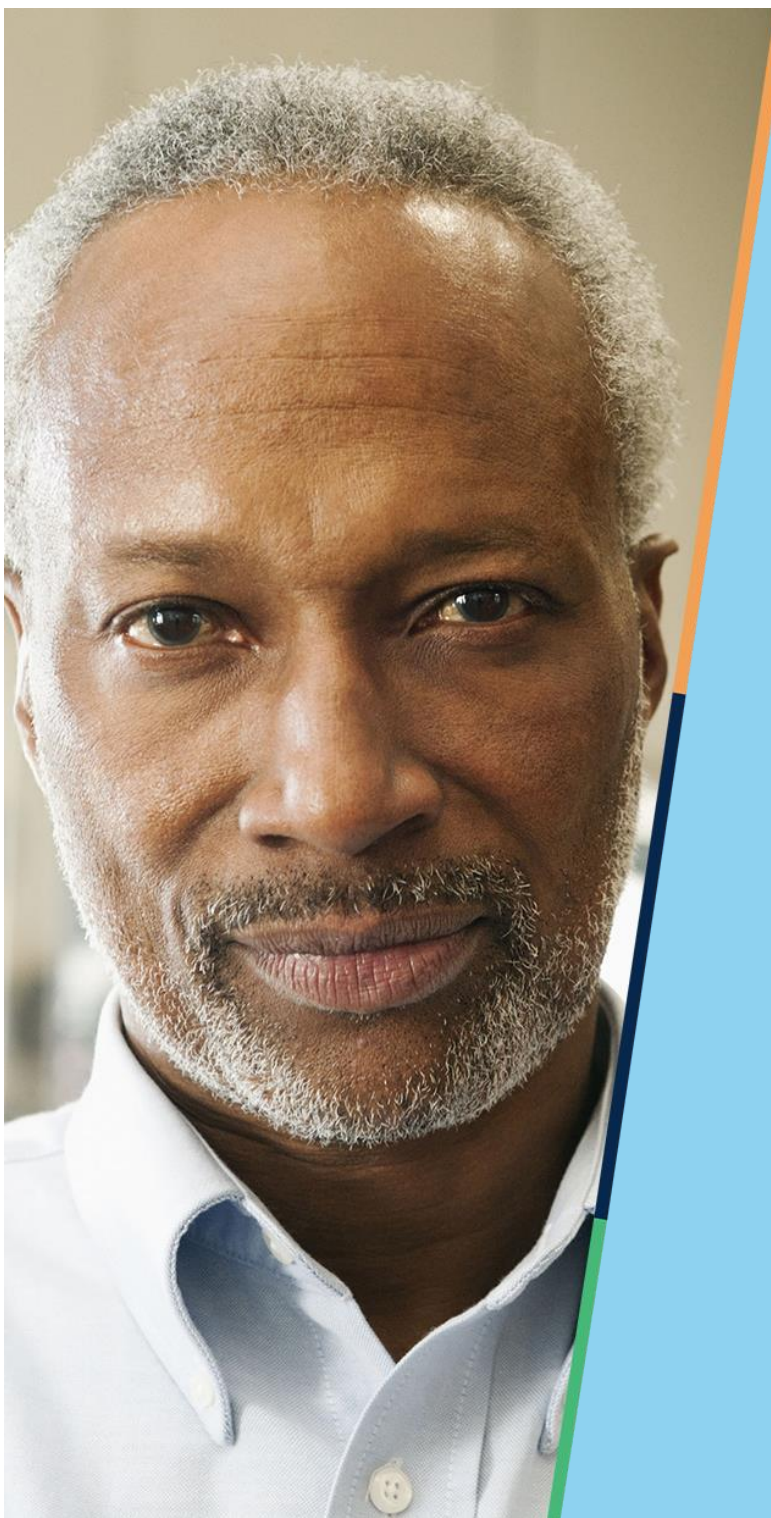
It is recommended that you use Internet Explorer when using ProviderConnect. Other internet browsers may not be compatible and may result in formatting or other visible differences.

New User?

Please register for access.

Register

For assistance with any technical problems (such as connecting to or accessing the site) please call our e-Support Help Line at 888-247-9311 during business hours Monday through Friday 8AM - 6PM ET or you can email an Applications Support Specialist at e-SupportServices@valueoptions.com



Authorization Procedures & Claim Submission

MBHP is a Beacon Health Options company.

ABA Authorization Requests

- All requests for authorization for ABA Assessment or ABA Services for MBHP and HNE Be Healthy Members is via an on-line application called Provider Connect.
- Providers complete and submit the request form on-line. All requests are reviewed by MBHP staff who will make a determination.

Enter an Authorization Request

<https://www.valueoptions.com/pc/eProvider/providerLogin.do>

The screenshot displays the ValueOptions provider portal interface. On the left is a vertical navigation menu with various options. The main content area is titled 'YOUR MESSAGE CENTER' and shows 'Your inbox is empty'. Below this is a section 'WHAT DO YOU WANT TO DO TODAY?' with several expandable menu items. A red arrow points to the 'Enter or Review Authorization Requests' item, which is further expanded to show 'Enter an Authorization Request' highlighted with a red box.

Navigation Menu (Left):

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

YOUR MESSAGE CENTER

INBOX

SENT

Your inbox is empty

WHAT DO YOU WANT TO DO TODAY?

- ▶ [Link/Unlink Accounts](#) **NEW**
- ▼ [Eligibility and Benefits](#)
 - [Find a Specific Member](#)
 - [Register a Member](#)
 - ▼ [Enter or Review Authorization Requests](#)
 - [Enter an Authorization Request](#)
 - [Review an Authorization](#)
 - [View Clinical Drafts](#)
- ▶ [Enter Member Reminders](#)
- ▼ [Enter or Review Claims](#)
 - [Enter a Claim](#)
 - [Enter EAP CAF](#)
 - [Review a Claim](#)
 - [View My Recent Provider Summary Vouchers](#)
 - [PaySpan](#)
- ▼ [Enter or Review Referrals](#)
 - [Enter a Referral](#)
 - [Review Referrals](#)
- ▶ [Enter Bed Tracking Information](#)
- ▶ [Search Beds/Opening](#)
- ▶ [Update ABA Paraprofessional Roster Information](#)
- ▶ [View My Recent Authorization Letter\(s\)](#)

URL: <https://www.valueoptions.com/pc/eProvider/searchDraftRequest.do>

Disclaimer



[ProviderConnect Home](#)

Disclaimer

Please note that ValueOptions recognizes only fully completed and submitted requests as formal requests for authorization. Exiting or aborting the process prior to completion will not result in a completed request. ValueOptions does not recognize or retain data for partially completed requests. Upon full completion of the " Enter an Authorization Request " process, you will receive a screen noting the pended or approved status of your request. Receipt of this screen is notification that your request has been received by ValueOptions.

[Next](#)

Search a Member



[ProviderConnect Home](#)

Search a Member

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

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

*Member ID (No spaces or dashes)
Last Name
First Name
*Date of Birth (MMDDYYYY)
As of Date (MMDDYYYY)

Member Demographics



[ProviderConnect Home](#)

Demographics | Enrollment History | COB | Benefits | Additional Information

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

Member?

Member ID	TESTBOMI2
Alternate ID	
Member Name	TEST, NO SPECIAL CHAR 2
Date of Birth	01/01/1900
Address	123 TEST STREET HOLTSVILLE, NY 00501
Alternate Address	
Marital Status	-
Home Phone	
Work Phone	
Relationship	1
Gender	M - Male

Eligibility

Effective Date	01/01/2015
Expiration Date	
COB Effective Date?	

Subscriber

Subscriber ID	TESTBOMI2
Subscriber Name	TEST, NO SPECIAL CHAR 2

Member Participates in Message Center Communication with Providers? **No**

If you wish to use the ProviderConnect Message Center to communicate with Members who participate in Message Center communication, please update your Profile and conduct a new Member Search for the Member you would like to contact.

[Next](#)

Select Servicing Address



[ProviderConnect Home](#)

Provider

Provider ID

PROVIDER, TEST (822964) ▼

Provider Last Name

ABA TEST PROVIDER

Provider First Name

TEST 1 2

Select Service Address

Capture	Provider		Vendor	
	Provider ID	Last Name First Name	Vendor ID	Vendor Last Name Vendor First Name
	Tax ID	Service Address	Paid To Vendor ID	Pay To Address
	Alternate ID			
<input checked="" type="radio"/>	822964	ABA TEST PROVIDER TEST 1 2	D481245	ABA TEST PROVIDER TEST 1 2
	123456789	10 BRITISH AMERICAN BLVD LATHAM, NY 12110-1415-		10 BRITISH AMERICAN BLVD LATHAM, NY 12110-1415-

[Back](#)

[Next](#)

ABA Assessment



[ProviderConnect Home](#)

Requested Services Header

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

*Requested Start Date (MMDDYYYY)

*Level of Service

*Type of Service

*Level of Care

*Type of Care
SELECT...
ABA ASSESSMENT
ABA SERVICES
BEHAVIORAL
MEDICATION MANAGEMENT
PSYCH TESTING

Provider

Tax ID	Provider ID	Vendor ID
123456789	822964	D481245

Member

Member ID	Last Name	First Name	Date of Birth (MMDDYYYY)
TESTBOM12	TEST	NO SPECIAL CHAR 2	01011900

Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

*Document Type:


Does this Document contain clinical information about the Member? Yes No

*Document Description:

Click to attach a document *Click to delete an attached document*

Attached Document:

ABA Assessment

ProviderConnect Home

ABA ASSESSMENT RESULTS

PAGE 1 of 2

Requested Services Header

Requested Start Date 06/12/2015	Member Name TEST, NO SPECIAL CHAR 3	Provider Name ABA TEST PROVIDER, TEST 1 2	Vendor ID D481245	<input type="button" value="Save Request as Draft"/>
Type of Request INITIAL	Member ID TESTBOMI3	Provider ID 822964	NPI # for Authorization SELECT...	
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Outpatient	Type of Care ABA ASSESSMENT	Authorized User <input type="text"/>

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

ABA Assessment

*Does member have an Autism Spectrum Disorder diagnosis? Yes No

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

Attach a Document

Uploaded documents are secure clinical

Document Description

Click to attach a document

Click to delete an attached document

Attached Document:

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

SELECT...

ABA Assessment

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

Attach a Document

Uploaded documents are secure clinical

Document Description

SELECT... ▼

UploadFile *Click to attach a document*

Delete *Click to delete an attached document*

Attached Document:

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

SELECT... ▼

Provide details on clinical rationale for testing and for the number of hours required as well as which assessment tools are to be used

(0 of 2000)

Diagnosis

*Documentation of **primary behavioral condition** is **required**. Provisional working condition and diagnosis should be documented if necessary. Documentation of **secondary co-occurring** impact or are a focus of treatment (mental health, substance use, personality, intellectual disability) is **strongly recommended** to support comprehensive care. Authorization (if applicable) and payment of benefits for these services. Coverage is subject to all limits and exclusions outlined in the member's plan and/or summary plan description including covered diagnoses.*

ABA Assessment Behavioral Diagnosis

Diagnosis

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

Behavioral Diagnoses

Primary Behavioral Diagnosis

* Diagnostic Category 1	* Diagnosis Code 1	* Description
AUTISM SPECTRUM DISORDER	F8 4.0	Autism Spectrum Disorder
SELECT...		
ALCOHOL-RELATED DISORDERS		
ANXIETY DISORDERS		
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER		
AUTISM SPECTRUM DISORDER		
BIPOLAR AND RELATED DISORDERS		
CANNABIS-RELATED DISORDERS		
COMBINED OTHER SUBSTANCE DISORDERS		
COMMUNICATION DISORDERS		
DEPRESSIVE DISORDERS		
DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS		
DISSOCIATIVE DISORDERS		
ELIMINATION DISORDERS		
FEEDING AND EATING DISORDERS - ANOREXIA & BULIMIA		
FEEDING AND EATING DISORDERS - BINGE EATING		
FEEDING AND EATING DISORDERS - OTHER		
GENDER DYSPHORIA		
HALLUCINOGEN-RELATED DISORDERS		
INHALANT-RELATED DISORDERS		
INTELLECTUAL DISABILITIES		
MEDICATION-INDUCED MOVEMENT DISORDERS AND OTHER ADVERSE EFFECTS OF MEDICATION		
NEUROCOGNITIVE DISORDERS		
OBSESSIVE-COMPULSIVE AND RELATED DISORDERS		
OPIOID-RELATED DISORDERS		
OTHER MENTAL DISORDERS		
OTHER NEURODEVELOPMENTAL DISORDERS		
PARAPHILIC DISORDERS		
PERSONALITY DISORDERS		
SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS		
SEDATIVE-, HYPNOTIC-, OR ANXIOLYTIC-RELATED DISORDERS		

ABA Assessment Behavioral Diagnosis

Diagnosis

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

Behavioral Diagnoses

Primary Behavioral Diagnosis

* Diagnostic Category 1

AUTISM SPECTRUM DISORDER ▼

*[Diagnosis Code 1](#)

F84.0

* [Description](#)

Autism Spectrum Disorder

Additional Behavioral Diagnosis

Diagnostic Category 2

SELECT... ▼

[Diagnosis Code 2](#)

[Description](#)

Diagnostic Category 3

SELECT... ▼

[Diagnosis Code 3](#)

[Description](#)

Diagnostic Category 4

SELECT... ▼

[Diagnosis Code 4](#)

[Description](#)

Diagnostic Category 5

SELECT... ▼

[Diagnosis Code 5](#)

[Description](#)

Primary Medical Diagnosis

ABA Assessment Medical Diagnosis

Primary Medical Diagnosis

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

*Diagnostic Category 1	Diagnosis Code 1	Description
NONE		
CIRCULATORY SYSTEM - HYPERTENSION		
CIRCULATORY SYSTEM - OTHER		
COMPLICATIONS OF PREGNANCY CHILDBIRTH AND THE PUERPERIUM		
CONGENITAL ANOMALIES		
DIGESTIVE SYSTEM - LIVER		
DIGESTIVE SYSTEM - OTHER		
DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS		
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS - CHRONIC PAIN		
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS - MIGRAINE		
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS - MULTIPLE SCLEROSIS		
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS - OTHER		
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS - PARKINSON'S		
ENDOCRINE NUTRITIONAL AND METABOLIC DISEASES AND IMMUNITY DISORDERS - DIABETES		
ENDOCRINE NUTRITIONAL AND METABOLIC DISEASES AND IMMUNITY DISORDERS - OTHER		
ENDOCRINE NUTRITIONAL AND METABOLIC DISEASES AND IMMUNITY DISORDERS - THYROID		
GENITOURINARY SYSTEM - KIDNEY		
* GENITOURINARY SYSTEM - OTHER		
INFECTIOUS & PARASITIC - HIV		
INFECTIOUS & PARASITIC - OTHER		
INJURY AND POISONING - OTHER		
INJURY AND POISONING - TBI		
MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE		
NEOPLASMS		
RESPIRATORY SYSTEM - COPD, ASTHMA, EMPHYSEMA		
RESPIRATORY SYSTEM - OTHER		
SKIN & SUBCUTANEOUS TISSUE		
SUPPLEMENTARY CLASSIFICATION OF EXTERNAL CAUSES OF INJURY AND POISONING		
SYMPTOMS SIGNS AND ILL-DEFINED CONDITIONS		
NONE		
UNKNOWN		

Housing problems
(Not Homelessness)

Occupational problems

Other psychosocial and
environmental problems

ABA Assessment

Social Elements Impacting Diagnosis

Social Elements Impacting Diagnosis

* Check all that apply

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Problems with access to health care services | <input type="checkbox"/> Housing problems (Not Homelessness) | <input type="checkbox"/> Problems related to the social environment |
| <input type="checkbox"/> Educational problems | <input type="checkbox"/> Problems related to interaction w/legal system/crime | <input type="checkbox"/> Occupational problems | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Problems with primary support group | <input type="checkbox"/> Other psychosocial and environmental problems | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Medical disabilities that impact diagnosis or must be accommodated for in treatment | | | |

Functional Assessment

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

Assessment Measure

SELECT...

Assessment Score

Secondary Assessment Measure

SELECT...

Assessment Score

Back

Submit

ABA Assessment Results



[ProviderConnect Home](#)

Determination Status: ***** **PENDED** *****

The services requested require additional review. You will be contacted regarding the status of this request if further information is needed. An authorization decision will be made within the required timeframes and details of that decision may be found under the member's authorization history.

Member Name S [REDACTED] N	Member ID [REDACTED]	Member DOB 12/02/1979	Subscriber Name [REDACTED]	Subscriber ID [REDACTED]
Pended Authorization # 121014-1-20	Client Authorization # N/A	Type of Request INITIAL		
Date of Admission/ Start of Services 12/10/2014	Requested From 12/10/2014	Submission Date 12/10/2014		
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service MENTAL HEALTH	Level of Care OUTPATIENT	Type of Care ABA ASSESSMENT	
Reason Code P84				
Provider Name & Address PETER TUMNUS 14 BEAVER TRAIL STE C NARNIA VA 123456	Provider ID 123456	NPI # for Authorization N/A		

Message
P84

Attached Documents

Document Title	Document Description
Test.doc	Secure-Clinical Document - Assessment/Eval

Authorization Printing & Downloading Options:

(For the best print results, please print in 'landscape' format)

- Print the Results page (this page)
- Print the entire Authorization Request
- Download the entire Authorization Request
- Return to the ProviderConnect homepage

ABA Services



[ProviderConnect Home](#)

Requested Services Header

All fields marked with an asterisk (*) are required.

Note: Disable pop-up blocker functionality to view all appropriate links.

*Requested Start Date (MMDDYYYY)

06182015

*Level of Service

OUTPATIENT

*Type of Service

MENTAL HEALTH

*Level of Care

OUTPATIENT

*Type of Care

SELECT...

SELECT...

ABA ASSESSMENT

ABA SERVICES

BEHAVIORAL

MEDICATION MANAGEMENT

PSYCH TESTING

DER

Vendor ID

D481245

Provider

Tax ID
123456789

Provider ID
822964

Member

Member ID
TESTBOM12

Last Name
TEST

First Name
NO SPECIAL CHAR 2

Date of Birth (MMDDYYYY)
01011900

Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

*Document Type:

Does this Document contain clinical information about the Member?

Yes No

*Document Description

SELECT...

UploadFile

Click to attach a document

Delete


Click to delete an attached document

Attached Document:

Back

Next

ABA Services

ProviderConnect Home

ABA SERVICE RESULTS

PAGE 1 of 2

Requested Services Header

Requested Start Date 06/18/2015	Member Name TEST, NO SPECIAL CHAR 3	Provider Name ABA TEST PROVIDER, TEST 1 2	Vendor ID D481245	<input type="button" value="Save Request as Draft"/>
Type of Request INITIAL	Member ID TESTBOMI3	Provider ID 822964	NPI # for Authorization SELECT...	
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Outpatient	Type of Care ABA SERVICES	Authorized User <input type="text"/>

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

ABA Service

*Does member have an Autism Spectrum Disorder diagnosis? Yes No

If yes, please complete the following information and documentation.

If previously submitted, please indicate Already submitted

*Name of professional who gave the diagnosis:

*License type of the professional:

*Date of the diagnostic assessment/diagnosis:

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

Attach a Document

Uploaded documents are secure clinical

Document Description: SELECT...

Click to attach a document

Click to delete an attached document

Attached Document:

ABA Services

Diagnosis

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

Behavioral Diagnoses

Primary Behavioral Diagnosis

* Diagnostic Category 1

AUTISM SPECTRUM DISORDER ▼

*[Diagnosis Code 1](#)

F84.0

* [Description](#)

Autism Spectrum Disorder

Additional Behavioral Diagnosis

Diagnostic Category 2

SELECT... ▼

[Diagnosis Code 2](#)

[Description](#)

Diagnostic Category 3

SELECT... ▼

[Diagnosis Code 3](#)

[Description](#)

Diagnostic Category 4

SELECT... ▼

[Diagnosis Code 4](#)

[Description](#)

Diagnostic Category 5

SELECT... ▼

[Diagnosis Code 5](#)

[Description](#)

Primary Medical Diagnosis

ABA Services Medical Diagnosis

Primary Medical Diagnosis

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

*Diagnostic Category 1	Diagnosis Code 1	Description
NONE		
CIRCULATORY SYSTEM - HYPERTENSION		
CIRCULATORY SYSTEM - OTHER		
COMPLICATIONS OF PREGNANCY CHILDBIRTH AND THE PUERPERIUM		
CONGENITAL ANOMALIES		
DIGESTIVE SYSTEM - LIVER		
DIGESTIVE SYSTEM - OTHER		
DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS		
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS - CHRONIC PAIN		
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS - MIGRAINE		
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS - MULTIPLE SCLEROSIS		
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS - OTHER		
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS - PARKINSON'S		
ENDOCRINE NUTRITIONAL AND METABOLIC DISEASES AND IMMUNITY DISORDERS - DIABETES		
ENDOCRINE NUTRITIONAL AND METABOLIC DISEASES AND IMMUNITY DISORDERS - OTHER		
ENDOCRINE NUTRITIONAL AND METABOLIC DISEASES AND IMMUNITY DISORDERS - THYROID		
GENITOURINARY SYSTEM - KIDNEY		
* GENITOURINARY SYSTEM - OTHER		
INFECTIOUS & PARASITIC - HIV		
INFECTIOUS & PARASITIC - OTHER		
INJURY AND POISONING - OTHER		
INJURY AND POISONING - TBI		
MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE		
NEOPLASMS		
RESPIRATORY SYSTEM - COPD, ASTHMA, EMPHYSEMA		
RESPIRATORY SYSTEM - OTHER		
SKIN & SUBCUTANEOUS TISSUE		
SUPPLEMENTARY CLASSIFICATION OF EXTERNAL CAUSES OF INJURY AND POISONING		
SYMPTOMS SIGNS AND ILL-DEFINED CONDITIONS		
NONE		
UNKNOWN		

Housing problems
(Not Homelessness)

Occupational problems

Other psychosocial and
environmental problems

ABA Services

Social Elements Impacting Diagnosis

Social Elements Impacting Diagnosis

* Check all that apply

- None
- Problems with access to health care services
- Housing problems (Not Homelessness)
- Problems related to the social environment
- Educational problems
- Problems related to interaction w/legal system/crime
- Occupational problems
- Homelessness
- Financial problems
- Problems with primary support group
- Other psychosocial and environmental problems
- Unknown
- Medical disabilities that impact diagnosis or must be accommodated for in treatment

Functional Assessment

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

Assessment Measure

SELECT...

Assessment Score

Secondary Assessment Measure

SELECT...

Assessment Score

ABA Services

Assessment Measure SELECT... ▼	Assessment Score	Assessment Measure SELECT... ▼	Assessment Score
-----------------------------------	------------------	-----------------------------------	------------------

*Is member receiving other professional services? Yes No

Speech Therapy Occupational Therapy Educational Tutor
 Individual Therapy Social Skills Group Therapy Other (specify in report)

*Is member taking any medication? Yes No

Please list the name, dosage, side effects (if any) and whether the member is compliant.

▶ Narrative History

▼ Narrative Entry (54 of 250)

risperidone one mg daily in AM, compliant with prompts

Current Impairments

ABA Services

Current Impairments and Skill Impairments

*Is member receiving other professional services? Yes No

*Is member taking any medication? Yes No

Current Impairments

Key:

0 = None 1 = mild/mildly incapacitating 2 = moderate/moderately incapacitating 3 = severe or severely incapacitating ANC = assessment not completed

*Danger to Self

0 1 2 3 ANC

*Danger to others

0 1 2 3 ANC

*Mood Disturbance (Depression or Mania)

0 1 2 3 ANC

*Anxiety

0 1 2 3 ANC

*Psychosis/Hallucinations/Delusions

0 1 2 3 ANC

*Impulsive/Reckless/Aggressive Behavior

0 1 2 3 ANC

Current Skills Impairments

Key:

0 = Age appropriate 1 = 1 to 2 years below 2 = 3-4 years below 3 = 5 or more years below ANC = assessment not completed

*Cognitive/Pre-Academic Skills

0 1 2 3 ANC

*Reduction of Interfering Behaviors

0 1 2 3 ANC

*Social Skills

0 1 2 3 ANC

*Play and Leisure Skills

0 1 2 3 ANC

*Community Integration

0 1 2 3 ANC

*Language/Communication Skills

0 1 2 3 ANC

*Safety Skills

0 1 2 3 ANC

*Adaptive and Self-Help Skills

0 1 2 3 ANC

*Coping and tolerance Skills

0 1 2 3 ANC

*Other (specify in report)

0 1 2 3 ANC

ABA Services Progress

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 the lack of progress. Include a summary of the Transitional/Discharge Plan and any additional resources or referrals that are needed for the member or their family.

▶ Narrative Entry (0 of 2000)

Please refer to <http://www.valueoptions.com/providers/Forms/Clinical/ABA-Provider-Progress-Report-Guidelines>. To download Value Options ABA report guidelines.

Providing the following components in the report will help with determining medical necessity

<i>Member's basic bio-psychosocial</i>	<i>Member's strengths/capabilities</i>
<i>Member's skill impairments</i>	<i>Crisis Plan</i>
<i>List of data source/tools used</i>	<i>Parent training</i>
<i>Intervention plan (including baseline data)</i>	<i>Coordination of care</i>
<i>Transition & discharge plan</i>	<i>Description of supervision</i>

Attach a Document

Uploaded documents are secure clinical

Document Description

SELECT...

UploadFile

Click to attach a document

Delete

Click to delete an attached document

Attached Document:

Back

Next

ABA Services



ProviderConnect Home

Requested Services Header

Requested Start Date 10/01/2015	Member Name [REDACTED]	Provider Name CARSON CENTER FOR HU, MAN SERVICES IN	Vendor ID [REDACTED]	Save Request as Draft
Type of Request INITIAL	Member ID [REDACTED]	Provider ID [REDACTED]	Provider Alternate ID [REDACTED]	NPI # for Authorization SELECT... ▾
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Outpatient	Type of Care ABA Services	Authorized User [REDACTED]

If your request is approved, you will receive 9999 visits.

If you agree to accept this number of visits, please select "Accept". If you do not agree, please select "Reject" and you may enter your modified request. Please be aware that if your request is above the offered number of units, it may be pended for additional clinical review.

Accept

Reject

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https://pcr3stg/pc/review/editUnitValue.do - Internet Explorer

Please enter number of visits you would like to request

Please enter the expiration date you would like for the request if approved
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 date exceeds allowed expiration date, system expiration date will apply.

Cancel Submit

ABA Services Requested Services


ProviderConnect Home

ABA SERVICE
REQUESTED SERVICES
RESULTS

PAGE 2 of 3

Requested Services Header

Requested Start Date	Member Name	Provider Name	Vendor ID	
06/18/2015	TEST, NO SPECIAL CHAR 3	ABA TEST PROVIDER, TEST 1 2	D481245	<input type="button" value="Save Request as Draft"/>
Type of Request	Member ID	Provider ID	NPI # for Authorization	
INITIAL	TESTB0H13	822964	SELECT...	
Level of Service	Type of Service	Level of Care	Type of Care	Authorized User
OUTPATIENT/COMMUNITY BASED	Mental Health	Outpatient	ABA SERVICES	<input type="text"/>

All fields marked with an asterisk () are required.
 Note: Disable pop-up blocker functionality to view all appropriate links.
 For certain types of care, further clinical review is required before units can be determined. In these cases, the total number of units available as displayed on the bottom of this page will be zero.
 Please indicate the CPT codes and any modifiers for services that are being requested. Units should remain as zero on request until this further clinical review is completed.*

[Click Here to Add or Modify Service Codes](#)

Requested Services

*Place of Service	*CPT or HCPC Code	Modifier 1 (If Applicable)	Modifier 2 (If Applicable)	Modifier 3 (If Applicable)	Modifier 4 (If Applicable)	*Visits/ Units
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	99999
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

ABA Services

Select Service Codes - Internet Explorer

[CLOSE WINDOW](#)

Save Close

NOTE: Select codes for this authorization request by checking the box next to the services being requested prior to saving the selection. Units being requested may be adjusted after saving codes. To de-select a code, uncheck the box. A limit of 10 services can be requested via this form - if additional services are required please indicate the services within the free text Focus of Care box or as an attachment to the request.

	Code	Mod 1	Mod 2	Mod 3	Mod 4	Description
<input type="checkbox"/>	H0032	U2				MENTAL HEALTH SERVICES PLAN DEVELOPMENT BY A NON-PHYSICIAN MEDICAID LEVEL OF CARE 2,AS DEFINED BY EACH STATE
<input type="checkbox"/>	H2012	U2				BEHAVIORAL HEALTH DAY TREATMENT, PER HOUR. MEDICAID LEVEL OF CARE 2,AS DEFINED BY EACH STATE
<input type="checkbox"/>	H2019	U2				THERAPEUTIC BEHAVIORAL SERVICES, PER 15 MINUTES. MEDICAID LEVEL OF CARE 2,AS DEFINED BY EACH STATE

Save Close

ABA Services

Level of Service
OUTPATIENT/COMMUNITY BASED

Type of Service
Mental Health

Level of Care
Outpatient

Type of Care
ABA Services

Authorized User

All fields marked with an asterisk (*) are required.

Note: Disable pop-up blocker functionality to view all appropriate links.

For certain types of care, further clinical review is required before units can be determined. In these cases, the total number of units available as displayed on the bottom of this page will be zero. Please indicate the CPT codes and any modifiers for services that are being requested. Units should remain as zero on request until this further clinical review is completed.

[Click Here to Add or Modify Service Codes](#)

Requested Services

*Place of Service	*CPT or HCPC Code	Modifier 1 (If Applicable)	Modifier 2 (If Applicable)	Modifier 3 (If Applicable)	Modifier 4 (If Applicable)	*Visits/ Units
HOME	H0032	U2				200
MENTAL HEALTH SERVICES PLAN DEVELOPMENT BY A NON-PHYSICIAN MEDICAID LEVEL OF CARE 2, AS DEFINED BY EACH STATE						
HOME	H2012	U2				0
BEHAVIORAL HEALTH DAY TREATMENT, PER HOUR. MEDICAID LEVEL OF CARE 2, AS DEFINED BY EACH STATE						
HOME	H2019	U2				100
THERAPEUTIC BEHAVIORAL SERVICES, PER 15 MINUTES. MEDICAID LEVEL OF CARE 2, AS DEFINED BY EACH STATE						
SELECT...						
SELECT...						
SELECT...						
SELECT...						
SELECT...						
SELECT...						
SELECT...						
SELECT...						
Total Visits/ Units						300

Instructions:

This request must include detailed information about CPT/HCPC procedure code(s) and the modifier, place of service, and number of visits/units requested for each procedure.

Please enter the details on this screen.

Note: TOTAL # OF UNITS CANNOT EXCEED 300

[Back](#) [Submit](#)

ABA Services Results

Determination Status:

***** **PENDE**D *****

The services requested require additional review. You will be contacted regarding the status of this request if further information is needed. An authorization decision will be made within the required timeframes and details of that decision may be found under the member's authorization history.

Member Name Test	Member ID Test	Member DOB 12/06/2013	Subscriber Name Test	Subscriber ID <input type="text"/>
Pending Authorization # 092215-1-8	Client Authorization # N/A	Type of Request INITIAL		
Date of Admission/ Start of Services 10/01/2015	Requested From 10/01/2015	Submission Date 09/22/2015		
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service MENTAL HEALTH	Level of Care OUTPATIENT	Type of Care ABA SERVICES	
Reason Code PB4				
Provider Name & Address Test 20 BROAD ST WESTFIELD MA 01085	Provider ID Test	Provider Alternate ID Test	NPI # for Authorization N/A	

Place of Service	CPT	Mod 1	Mod 2	Mod 3	Mod 4	Service Class	Description	Visits Requested/Approved
12						AB3	ABA Services	200/ 0
12								0/ 0
12								100/ 0
Total Units For Auth 092215-1-8 From 10/01/2015 To 04/01/2016 Total Units Authorized This Episode For 092215-1-8								0

Message

PB4

Attached Documents There are no documents attached with this Authorization Request

Document Title	Document Description
----------------	----------------------

Authorization Printing & Downloading Options:
(For the best print results, please print in 'Landscape' format)

- [Print Authorization Result](#)
Print the Results page (this page)
- [Print Authorization Request](#)
Print the entire Authorization Request
- [Download Authorization Request](#)
Download the entire Authorization Request
- [Return to Provider Home](#)
Return to the ProviderConnect homepage

Concurrent Request



[ProviderConnect Home](#)

Requested Services Header

All fields marked with an asterisk (*) are required.

Note: Disable pop-up blocker functionality to view all appropriate links.

*Requested Start Date (MMDDYYYY)

06182015



*Level of Service

OUTPATIENT

*Type of Service

MENTAL HEALTH

*Level of Care

OUTPATIENT

*Type of Care

ABA SERVICES

Provider

Tax ID	Provider ID	Provider Last Name	Vendor ID
123456789	822964	ABA TEST PROVIDER	D481245

Member

Member ID	Last Name	First Name	Date of Birth (MMDDYYYY)
TESTBOMI2	TEST	NO SPECIAL CHAR 2	01011900

Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

*Document Type:

Does this Document contain clinical information about the Member?

Yes No

*Document Description

SELECT...

UploadFile

Click to attach a document

Delete

Click to delete an attached document

Attached Document:

Back

Next

Concurrent Request



[ProviderConnect Home](#)

Requested Services Header

Requested Start Date 06/18/2015	Member Name TEST, NO SPECIAL CHAR 2	Provider Name ABA TEST PROVIDER, TEST 1 2	Vendor ID D481245
Type of Request CONCURRENT	Member ID TESTBOMI2	Provider ID 822964	NPI # for Authorization SELECT... ▼
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Outpatient	Type of Care ABA SERVICES

There is an existing authorization that bridges this date range.

Is this a request for continuing care (concurrent request) or do you wish to enter Discharge information?

Process Continuing Care (Concurrent) Request

Enter Discharge Information

Cancel

Concurrent Request



ProviderConnect Home

ABA SERVICE RESULTS

PAGE 1 of 2

Requested Services Header

Requested Start Date 06/18/2015	Member Name TEST, NO SPECIAL CHAR 2	Provider Name ABA TEST PROVIDER, TEST 1 2	Vendor ID D481245	<input type="button" value="Save Request as Draft"/>
Type of Request CONCURRENT	Member ID TESTBOMI2	Provider ID 822964	NPI # for Authorization SELECT...	
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Outpatient	Type of Care ABA SERVICES	Authorized User <input type="text"/>

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

ABA Service

Follow-up considerations for concurrent review

Additional information requested from ValueOptions Clinician
Things to keep in mind going through Concurrent request

*Does member have an Autism Spectrum Disorder diagnosis? Yes No

If yes, please complete the following information and documentation.

If previously submitted, please indicate

Already submitted

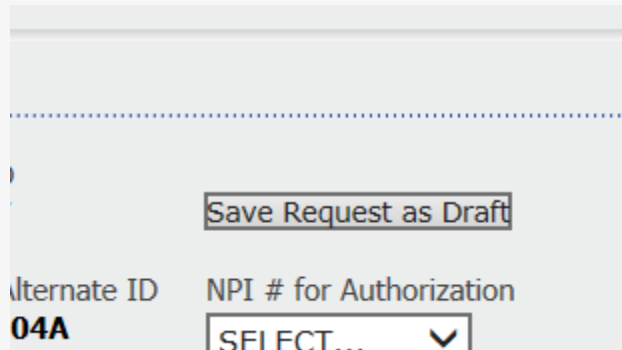
*Name of professional who gave the diagnosis:

*License type of the professional:

*Date of the diagnostic assessment/diagnosis:

PC TIP

When filling out any of the authorization request forms, there is an option to save the request as a draft, so you can complete it later. Use the *Save Request as Draft* button located in the upper right corner of each screen.



Keep in mind, the saved draft has not been submitted to MBHP. You must remember to go back to it, complete the form, and submit it.

Direct Claim Submission

- Provides ability to enter a claim directly into ProviderConnect portal without using special software
- Expedites processing of the claim and payment
- Available for professional services only, not higher levels of care
- Recommended for providers submitting a lower volume of outpatient claims

Direct Claim Submission

The screenshot displays the ValueOptions ProviderConnect interface. At the top, the logo 'PROVIDERCONNECT VALUEOPTIONS' is on the left, and navigation links 'ValueOptions Home', 'Provider Home', 'Contact Us', and 'Log Out' are on the right. A left-hand navigation menu lists various services such as 'Home', 'Specific Member Search', 'Register Member', 'Authorization Listing', 'Enter an Authorization Request', 'View Clinical Drafts', 'Claim Listing and Submission', 'EDI Homepage', 'Enter Member Reminders', 'On Track Outcomes', 'Reports', 'My Online Profile', 'My Practice Information', 'Provider Data Sheet', 'Compliance', 'Handbooks', 'Forms', 'Network Specific Information', 'Education Center', 'ValueSelect Designation', and 'Contact Us'. The main content area features a welcome message: 'Welcome TEST PROVIDER . Thank you for using ValueOptions ProviderConnect.' Below this is a 'YOUR MESSAGE CENTER' section with an 'INBOX' icon and a 'SENT' icon. A message states 'Your Recent Inquiries box is empty'. Under the heading 'WHAT DO YOU WANT TO DO TODAY?', there are several expandable menu items. The 'Enter or Review Claims' menu is expanded, and the 'Enter a Claim' option is highlighted with a red box and a red arrow pointing to it. Other options include 'Eligibility and Benefits', 'Enter or Review Authorization Requests', and 'Enter Member Reminders'.

PROVIDERCONNECT
VALUEOPTIONS

ValueOptions Home Provider Home Contact Us Log Out

Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
View Clinical Drafts
Claim Listing and Submission
EDl Homepage
Enter Member Reminders
On Track Outcomes
Reports
My Online Profile
My Practice Information
Provider Data Sheet
Compliance
Handbooks
Forms
Network Specific Information
Education Center
ValueSelect Designation
Contact Us

Welcome TEST PROVIDER . Thank you for using ValueOptions ProviderConnect.

INBOX

SENT

YOUR MESSAGE CENTER

Your Recent Inquiries box is empty

WHAT DO YOU WANT TO DO TODAY?

- Eligibility and Benefits
 - Find a Specific Member
 - Register a Member
- Enter or Review Authorization Requests
 - Enter an Authorization Request
 - Review an Authorization
 - View Clinical Drafts
- Enter Member Reminders
- Enter or Review Claims
 - Enter a Claim
 - Review a Claim
 - View My Recent Provider Summary Vouchers
- View My Recent Authorization Letters

Direct Claim Submission



[ProviderConnect Home](#)

Provider

Provider

PROVIDER, TEST (822964) ▼

Provider Last Name

PROVIDER

Provider First Name

TEST

Select Service Address

Capture	Vendor ID	Service Address	Pay To Address
<input checked="" type="radio"/>	D481245	TEST PROVIDER 10 BRITISH AMERICAN BLVD LATHAM, NY 12110-1415	TEST 1 2 ABA TEST PROVIDER 10 BRITISH AMERICAN BLVD LATHAM, NY 12110-1415

Back

Next

Direct Claim Submission



[ProviderConnect Home](#)

Submit A Claim - Step 1 of 3

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


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

Provider Name	PROVIDER TEST
Service Address	10 BRITISH AMERICAN BLVD,LATHAM,NY,12110-1415
Pay To Address	10 BRITISH AMERICAN BLVD,LATHAM,NY,12110-1415
Vendor ID	D481245
NPI Number	1234567890
Taxonomy Code	
Licensure Level	Select...
*Member ID	TESTBOMI2 <small>(X-digits, no spaces or dashes)</small>
Member Name	<input type="text"/> <input type="text"/> <small>(First Last)</small>
Member Account #	<input type="text"/> <small>(X-digits, no spaces or dashes)</small>
Program/Fund/Group ID	<input type="text"/>
*Member DOB	01011900 <small>(MMDDYYYY)</small>
*First Date of Service	06012015 <small>(MMDDYYYY - Enter Earliest Date of Service for this claim)</small>
*Is this claim being billed under EAP Services?	<input type="radio"/> Yes <input checked="" type="radio"/> No

[Previous](#)

[Next](#)

Direct Claim Submission

 [ProviderConnect Home](#)

Submit A Claim - Step 2 of 3

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

Member ID	Member Name	Birth Date	NPI Number	Service Address	Pay To Address
TESTBOMI2	NO SPECIAL CHAR 2 TEST	01/01/1900	1234567890	10 BRITISH AMERICAN BLVD,LATHAM,NY,12110-1415	10 BRITISH AMERICAN BLVD,LATHAM,NY,12110-1415

Frequency Type:

ORIGINAL
CORRECTED
REPLACEMENT
VOID

Original Reference Number:

on fields(s) if Coordination of Benefit (COB) information is applicable to dates of service on this claim. i.e., If any payment from other to this claim.

Does a COB exist for this claim:
 Yes No

Other Payer Information - Primary

Other Payer Information - Secondary

Other Payer Information - Tertiary

Direct Claim Submission

Submit A Claim - Step 3 of 3

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

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

To enter detail service lines for the claim, please follow these steps:

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

Must be
Capital
Letters

Service Line Entry

*Service From: 08012015 (MMDDYYYY)
*Service Through: 08012015 (MMDDYYYY)
*Service Code: H2012 (ex: 86753)
Modifier Code 1: U2 (no spaces or dashes)
Modifier Code 2: (no spaces or dashes)
Modifier Code 3: (no spaces or dashes)
Modifier Code 4: (no spaces or dashes)
NDC Number: (no spaces or dashes)

*Charge Amount (\$): 123.45 (ex: 123.45)
*Place of Service: 11 (00 - 99)
*Units: 004 (3-digits)
NDC Units: (ex: 765.4 OR 765.0)
Type of Units: Select...

*Diagnosis Code 1: F84 (ex: 765.4)
Diagnosis Code 2: (ex: 765.4)
Diagnosis Code 3: (ex: 765.4)
Diagnosis Code 4: (ex: 765.4)
Diagnosis Code 5: (ex: 765.4)
Diagnosis Code 6: (ex: 765.4)
Diagnosis Code 7: (ex: 765.4)
Diagnosis Code 8: (ex: 765.4)

Primary Payer		Secondary Payer		Tertiary Payer	
COB Payer Paid 1	COB Units Paid 1	COB Payer Paid 2	COB Units Paid 2	COB Payer Paid 3	COB Units Paid 3
(ex: 99999.99)	(ex: 999)	(ex: 99999.99)	(ex: 999)	(ex: 99999.99)	(ex: 999)

Add Service Line

This will add this service line information to the claim

Direct Claim Submission

Claim Detail: Ready to Submit

Click to Remove	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	COB Payer Paid			NDC Number
	Start Date	End Date	Place of Service	Modifier Code 3	Modifier Code 4		Primary	Secondary	Tertiary	NDC Units/Type of Units	
<input type="radio"/>	08012015	08012015	H2012 11	U2		123.45	F84				
Total								0.00	0.00	0.00	

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

Attach an EOB

Click Upload File to attach a COB EOB with this claim.

Upload File

This will attach an EOB document to the claim.

Attached Documents:

Remove

This will remove the service line selected above

Submit

This will submit the entire claim (including all service lines added)

Previous

This will return to the preceding data entry page

Summary Page

Submit A Claim

Submission Results : ***** CLAIM ENTERED *****

Your claim has been submitted successfully. You may contact Claims Customer Service with any questions related to this claim.

Provider Name/ ID **PROVIDER-822964**
Vendor ID **D481245**
Patient ID **TESTBOM12**
Patient Name **TEST, NO SPECIAL CHAR 2**
Program/Fund/Group ID
Patient Date of Birth **01/01/1900**
NPI Number **1234567890**
Taxonomy Code
Licensure Level
Claim # [123101-00004-00004](#)

Line #	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	COB Payer Paid			NDC U
	Start Date	End Date						Place of Service	Modifier Code 3	Modifier Code 4	
1	08012015	08012015	H2012 11			95.00	F84	0.00	0.00	0.00	
Total								0	0	0	

Attached EOBs :

Document1Title.doc

[Enter New Claim](#)

Contact Information

ValueOptions EDI Helpdesk (ProviderConnect Technical Questions)

Monday through Friday, 8:00 a.m. - 6:00 p.m. ET

Phone: (888) 247-9311

Email: e-supportservices@valueoptions.com

MBHP

1-800-495-0086

Questions?

