



Account Request Form
Please fax completed form to 866-698-6032.
Questions on this form? Call 888-247-9311 (option 3)

Online Provider Services

Provider, Practice or Facility Name

ValueOptions Provider ID (If not known, contact your local ValueOptions Service Center or call National Networks 800-397-1630)

Provider, Practice or Facility Tax ID (do not include the dash)

Provider, Practice or Facility Vendor Number(s). You may have several, one for each service location. (If not known, contact your local ValueOptions Service Center or call National Networks 800-397-1630)

Address Line 1

Address Line 2

City State Zip Code

Telephone Number Fax Number

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

- Electronic Batch Claims Submission (Claim batch file uploads)
Single Claims Submission (Directly on website)
Eligibility Inquiry
Claim Status Inquiry

Provider named above will be submitting their own claims Yes No (N/A if only requesting inquiry status)

Provider has retained a Billing Agent, Clearinghouse, or Intermediary to submit claims on their behalf. Yes No (N/A if only requesting inquiry status)

Please note, depending on the types of claims you will be submitting (i.e. Medicaid vs. Commercial), you may need multiple accounts created to ensure the claims are processed accurately. Therefore, to help us in setting up your account(s) correctly, please answer the following:

- If you are located in AZ, will you be submitting AZ Medicaid Claims?
If you are located in CO, will you be submitting CO Medicaid Claims?
If you are located in MA, will you be submitting MBHP Claims?
If you are located in NM, will you be submitting NM Medicaid Claims?
If you are located in PA, will you be submitting SWPA Medicaid Claims?
If you are located in TX, will you be submitting TX NorthSTAR Claims?

E-mail address where you would like to receive your electronic claims file feedback.

Contact E-mail address

Contact Name



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Agreement Terms:

- A. The undersigned submitter authorizes ValueOptions to receive and process claims via the ValueOptions Electronic Transport System (ETS) or ValueOptions Online Provider Services Program on his/her/its behalf in accordance with the applicable regulations.
B. All submitted information must be true, accurate and complete. I/We understand that payment of any claim submitted in falsification or concealment of a material fact may be prosecuted under any applicable state and/or federal laws.
C. The Submitter agrees to comply with any laws, rules and regulations governing the ValueOptions Online Provider Services/EDI program.
D. The Submitter agrees to accept, as payment in full, the amounts paid in accordance with the fee schedules provided for under the ValueOptions EDI program.
E. This is to certify that an exact copy of any claim files submitted via the ValueOptions ETS system or Online Provider Services program will be stored in an electronic medium and held by the originator for a period of 90 days or until the submission has been finalized as to reimbursement or denial of payment, whichever comes first.

This is to certify that the following is true:

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

Signatures:

Legal name of Organization (please print or type) Title of individual signing for organization

Name of Individual Signing for Organization Provider's Authorizing Signature Date
ValueOptions, Inc 2005