



Account Request Form
Please fax this completed form along with the Intermediary Authorization Form to SecureConnect® at 916-853-5136.

1. Provider, Practice or Facility Name

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

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

Provider, Practice or Facility Vendor Number(s) (If applicable, you may have one for each service location.)

4a. 4b. 4c.

4d. 4e. 4f.

5a. Address Line 1

5b. Address Line 2

5c. City 5d. State 5e. Zip Code

6a. Telephone Number 6b. Fax Number

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

Electronic Claims Submission Online Eligibility Inquiry Online Claim Status Inquiry

8a. Provider named in box 1 above will be submitting their own claims Yes No

8b. Provider has retained a Billing Agent, Clearinghouse, or Intermediary to submit claims on their behalf. Yes No

9. Please check the following box if you would like to receive the HIPAA 835 Electronic Remittance Advice.

HIPAA 835 ERA\*

\*If you chose to receive the HIPAA 835 ERA, we will need all associated ValueOptions vendor numbers along with your Value Options provider number. Also, if you are using a billing agency and would like for them to receive your HIPAA 835 ERA, please provide us with their Submitter ID.

10a. E-mail address where you would like to receive your electronic claims file feedback.

Note: If you do not have an internet e-mail account, we will create a mailbox on our system for your feedback.

10b. Contact E-mail address

10c. Contact Name



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11. 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 an assigned agent of a Provider. I have provided a completed Intermediary Authorization Form for each of the providers listed in any claim files submitted electronically to ValueOptions.

12a. Signatures:

Legal name of Organization (please print or type)

Title of individual signing for organization

Name of Individual Signing for Organization

Authorizing Signature (Person with signing authority)

Date
ValueOptions, Inc 2002