Connecticut BHP
Supporting Health and Recovery

Online Provider Services Account Request Form

Required fields are marked with an asterisk. *
Fax completed form to 855-750-9862 or
email to ctbhp@beaconhealthoptions.com
Questions on this form? Read instructions on page 2

Special Setup: (See page 2)

☐ Additional Login Account

☐ New Combined Account
Existing Combined Account
Login ID: ___________________

*Provider, Practice or Facility Name

*Beacon Health Options assigned Provider ID (CBHP#) or Medicaid ID# (005555555)

*Address

*City *State *Zip Code

*User's First and Last Name

*User's Email Address

*Telephone Number: ______________________________ Fax Number: ______________________________

Agreement Terms:

A. The undersigned submitter authorizes Beacon Health Options to receive and process claims or batch registration submissions via the Beacon Health Options Electronic Transport System (ETS) or Beacon Health Options 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 Beacon Health Options Online Provider Services/EDI program.

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

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

This is to certify that the following is true:

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

Signatures:

Legal name of Organization Title of individual signing for organization

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

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