



Online Provider Services Intermediary Authorization Form

Purpose: This form should be completed by providers who contract with a third party to submit claims. If the Billing Intermediary will submit claims for multiple providers, an Account Request Form and an Intermediary Authorization Form is required for each provider. All fields must be completed.

Billing Agent/Clearinghouse / Intermediary Information:

Provider Information:

Billing Intermediary Name

Provider Name

Billing Intermediary's Submitter ID (if already established)

Provider NPI Number

Contact Name at Billing Intermediary

Provider Tax ID

Email Address at Billing Intermediary

Beacon Health Options Assigned Provider ID

Phone Number at Billing Intermediary

Please check those options for which you have been authorized by the below-signed provider.

- Batch Claim Submission & Claim Adjustment (837 HIPAA)
- Direct Claim Submission & Claim Adjustment (ProviderConnectSM)

Automatically included:
 ✓ Eligibility Inquiry
 ✓ Claim Status
 ✓ Authorization Inquiry
 ✓ Provider Summary Vouchers

Agreement Terms:

- A. The undersigned Provider authorizes the above Billing Intermediary to submit claims to Beacon Health Options, Inc. (Beacon) on his / her / its behalf in accordance with any applicable regulations.
- B. The provider warrants that he / she / it has entered into a written agreement with above named Billing Intermediary. The provider understands and agrees that its use of this Billing Intermediary does not in any manner relieve the provider of full responsibility and liability for any violations of the laws, regulations and rules which govern the Beacon EDI program.
- C. The provider accepts full liability for all actions of the above named Billing Intermediary within its actual or apparent authority to act on behalf of the provider, notwithstanding any contrary provisions in the agreement between the provider and the Billing Intermediary. In the case of any violations of applicable laws, rules and regulations governing the Beacon EDI program, which arise out of the actions of the Billing Intermediary, the provider accepts full liability as though these actions were the provider's own actions.
- D. The provider agrees to notify Beacon in writing at least ten (10) days prior to the effective date of the revocation of this Intermediary Authorization Form. In such event, the provider's liability for the acts of the Billing Intermediary will continue until the tenth day after the receipt of such notification or the effective date of the revocation, whichever is later.

Signatures:

Billing Intermediary's Signature

Provider or Authorized Provider's Staff Signature

Date

Date