

**Illinois Department of Human
Services,
Division of Mental Health/
The Illinois Mental Health
Collaborative
for Access and Choice**

**FY 2011 REQUEST FOR
AUTHORIZATION**

**ELECTRONIC SUBMISSION
PROCESS**

Agenda

Overview of the Authorization Process

Electronic Submission Process for Community Support Group (CSG) . Live Demo

Electronic Submission Process for Psychosocial Rehabilitation (PSR) . Live Demo

Electronic Submission Process for Therapy/Counseling (T/C) . Live Demo

Overview of the Authorization Process

- Authorization for payment of services is required after January 3, 2011 for any consumer receiving services above and beyond the threshold hours/units of service
- Authorization request form with a Mental Health Assessment (MHA) and Individual Treatment Plan (ITP), along with any other supporting documentation to establish Medical Necessity Criteria
- Submit authorization request electronically through ProviderConnect and supporting clinical documentation either as secure clinical attachments with request or via facsimile

Necessary items for submitting an authorization

- Authorization request via ProviderConnect - All required and applicable fields completed. The Collaborative will not review requests for authorization submitted via facsimile.
- Current MHA and ITP - Securely attached with ProviderConnect request or faxed to the Collaborative (866-928-7177) within 1 business day
- Additional documentation - May be necessary if the MHA and ITP do not fully support medical necessity for the request. This information must also be securely attached with ProviderConnect request or faxed to the Collaborative (866-928-7177) within 1 business day.
- If required supporting materials (MHA, ITP, etc.) are not included with request/received within 1 business day, the Collaborative staff will contact the provider to explain the additional information that is required and the request will be closed without review. The provider must resubmit the entire request for authorization with all supporting documentation.

- If choosing to fax, rather than attach to the on-line request, the supporting clinical documentation for the request (e.g. MHA, ITP, etc.), please ensure that each consumer's information is faxed separately.
- If choosing to fax, rather than attach to the on-line request, the supporting clinical documentation for the request (e.g. MHA, ITP, etc.), please ensure that the service being requested is noted on the fax cover sheet.

When to submit a request for authorization

Therapy/Counseling

- Eligible Consumers are able to initially receive up to 10 hours (40 units) of this service, if provider LPHA deems medically necessary, without submission of an authorization request
- If provider deems additional hours (units) of T/C are medically necessary above and beyond the 10 hour (40 unit) threshold, a request for authorization must be submitted **and** authorization must be obtained in order to be reimbursed for services

PSR & Community Support Group

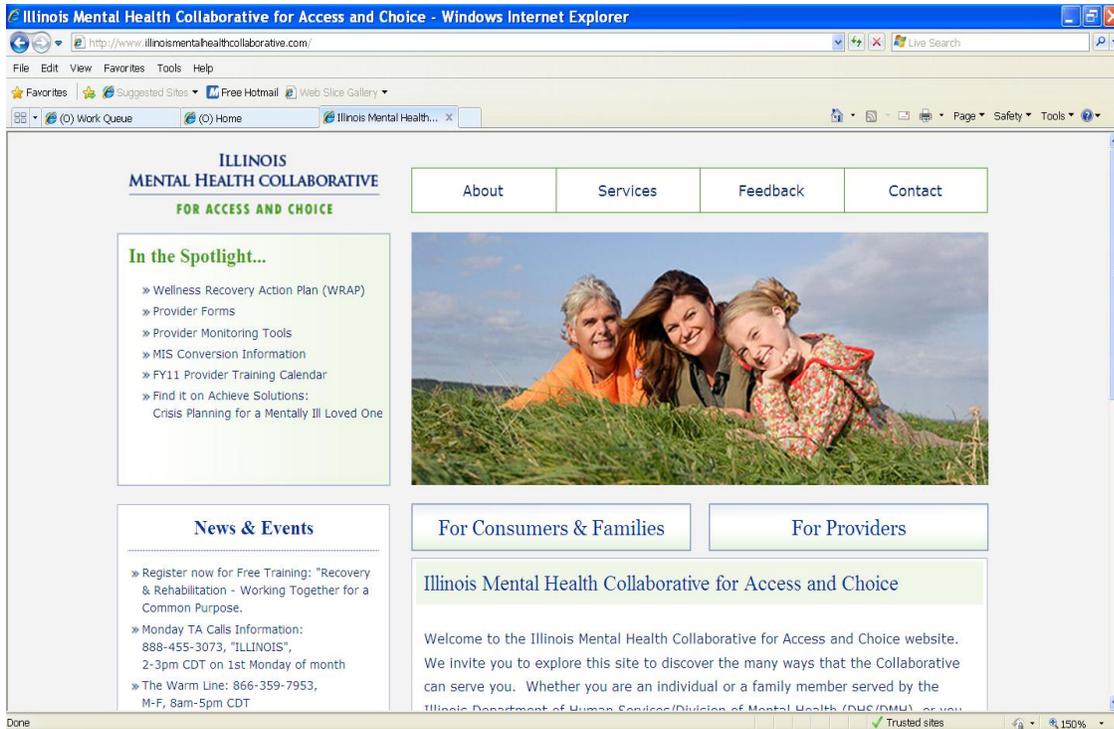
- Eligible Consumers are able to initially receive up to 200 hours (800 units) of PSR, CSG, or a combination of PSR & CSG, if provider deems medically necessary, without submission of an authorization request
- If provider LPHA deems additional hours (units) are medically necessary above and beyond the 200 hour (800 unit) threshold, a request for authorization must be submitted **and** authorization must be obtained in order to be reimbursed for services

Please utilize the following workflows to assist you in completing your on-line request for authorization submissions. Please note that there are examples provided of the of blank fields in the requests, as well as completed fields in order to demonstrate the difference in appearance.

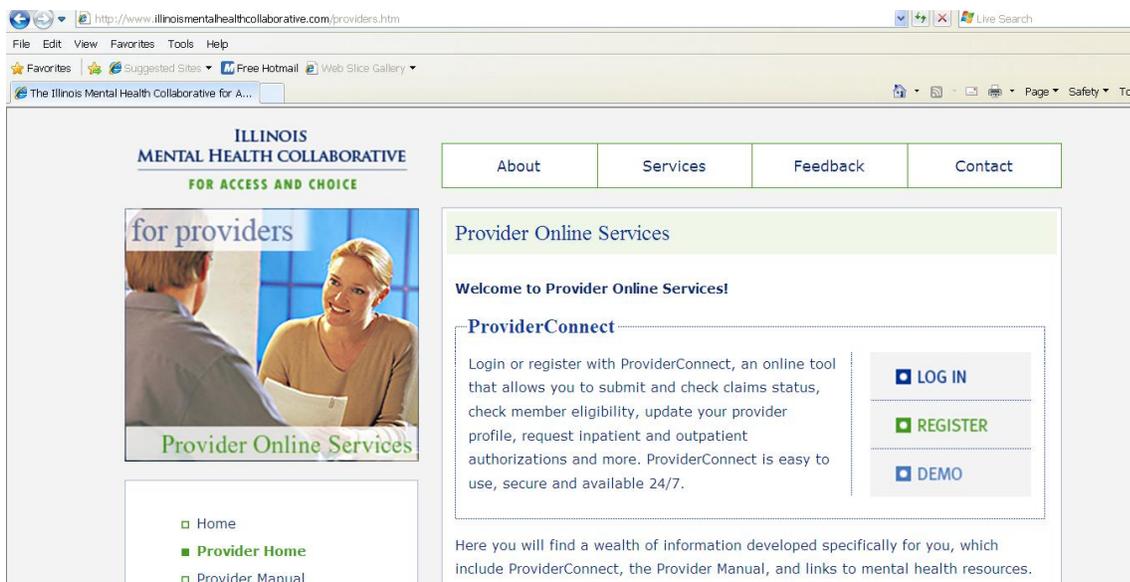
Electronic Submission Process for Community Support Group (CSG)

1. Go to Illinois Mental Health Collaborative website:

<http://www.illinoismentalhealthcollaborative.com>



2. Once at the homepage, click the **For Providers** tab



3. Click the **Log In** tab
4. Enter User ID

5. Enter Password
6. Click the **Log In** tab

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

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

*Password

[Forgot Your Password?](#)

Log In

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.

7. Provider will see the Use Agreement

ProviderConnect Use Agreement

Welcome to www.valueoptions.com, the website for ValueOptions, Inc.

Please carefully read the terms of this Agreement before you click the "I Agree" button. If, after reading the terms you agree on behalf of yourself and your company or organization or facility to be bound by this Agreement, you must click the "I Agree" button at the end of this screen in order to proceed

By clicking the "I Agree" button and accessing or using the ProviderConnect site or any of the online services available, you, on behalf of yourself and your company or organization or facility: (1) represent and warrant that you have the capacity and authority to enter into this Agreement; (2) agree to be bound by the terms and conditions of this Agreement; and (3) acknowledge and agree all transactions and services conducted through ProviderConnect are and carry full legal authority as if same were transacted or conducted on paper. You will need to request a user name and password for access to certain online services available on ProviderConnect.

If you do not wish to be bound by the terms and conditions of this Agreement, or do not have the legal authority to enter into this Agreement, you may not proceed or use any of the transactions or services available on ProviderConnect.

This ProviderConnect Use Agreement (the "Agreement") is between you and ValueOptions, Inc. on behalf of itself and its affiliates and subsidiaries ("ValueOptions®") and governs your use of ProviderConnect. By accessing the ProviderConnect site or using any of the online services available, you agree to the following terms:

Provider Agreement. If you or your company, organization or facility have a participation or facility agreement in effect with ValueOptions, your use of ProviderConnect and any online transactions or services accessed thereunder is also subject to the terms and conditions of that provider agreement. If you or your company, organization or facility do not have a participation or facility agreement in effect with ValueOptions, your use of ProviderConnect and any online transactions or services accessed there under are subject to the terms of this Agreement.

8. At the bottom of this page, provider will see tabs indicating agreement or disagreement.

and/or your use or misuse of ProviderConnect and/or any online transactions or services available thereunder and/or information contained within or transmitted through ProviderConnect by you or your authorized designee.

Updates & Modifications. ValueOptions, in its sole discretion, may update or modify this Agreement from time to time. ValueOptions will provide notice of updates or modifications to this Agreement on this website. If you continue to use or access the ProviderConnect site following such notice, you are deemed to have accepted the updated or modified Agreement and agreed to all of the terms and conditions contained therein. This Agreement is available on the ProviderConnect site. You agree to review this Agreement periodically.

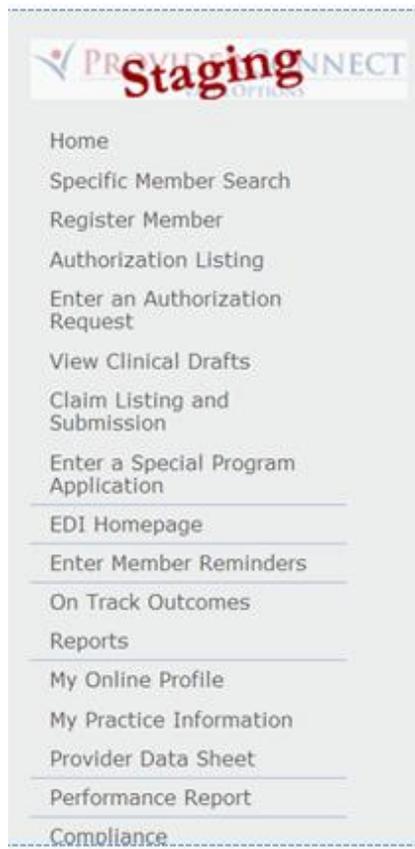
Assignment & Governing Law. You may assign this Agreement only with the prior written consent of ValueOptions. This Agreement and all disputes, lawsuits and claims relating to this Agreement shall be governed by the laws of the Commonwealth of Virginia, excluding its conflicts of law rules.

Termination. You may terminate this Agreement by providing written notice to ValueOptions and discontinuing your use of ProviderConnect. ValueOptions may terminate this Agreement and your right to access or use ProviderConnect at any time, with or without cause.

676767
ILLINOIS TRAINING
123 TRAINING AVE
CHICAGO, IL 60290

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

9. If provider wishes to continue with the process, provider will click the **I Agree** tab. The provider will be taken to the ProviderConnect home page and will select **Specific Member Search** from the options on the left hand side of the page.



10. Provider will be taken to the **Eligibility and Benefits Search** screen.
11. Enter required fields: Member ID (9 digit RIN) and Date of Birth
12. Click **Search** tab

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
 Enter a Special Program Application
 EDI Homepage
 Enter Member Reminders
 On Track Outcomes
 Reports
 My Online Profile
 My Practice Information
 Provider Data Sheet
 Performance Report
 Compliance

Eligibility & Benefits Search

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 11162010 (MMDDYYYY)

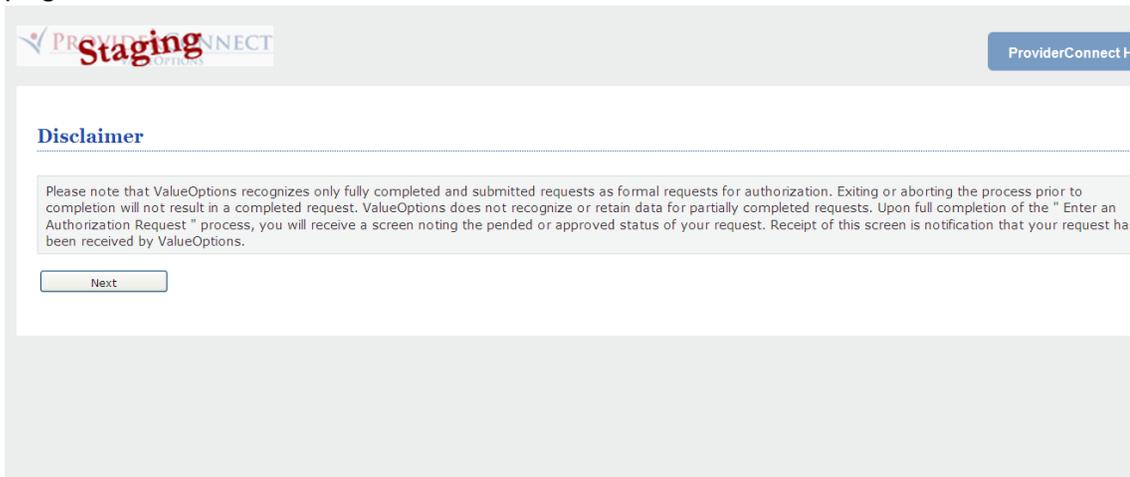
13. Provider will be taken to the %Demographics+screen for the consumer
14. Click the %Enter an Authorization Request+tab at the left hand side of the screen

Demographics Enrollment History COB Benefits Additional Information

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

Consumer?		Eligibility
Consumer ID	ILLTEST01	Effective Date
Alternate ID		Expiration Date
Consumer Name	MEMBER01, ILLTEST	COB Effective Date?
Date of Birth	01/01/1980	View Funding Source Enrollment De
Address	1 TEST DRIVE APT 2D CHICAGO, IL 60608	
Alternate Address		Subscriber
Marital Status	-	Subscriber ID
Home Phone		Subscriber Name

15. Provider will be taken to the %Disclaimer+
page



16. If provider wishes to proceed with authorization request, they will click the %Next+
tab

17. Provider will be taken to the Provider screen

Provider

Provider ID: ILLINOIS TRAINING - 676767
 Provider Last Name: ILLINOIS TRAINING
 Provider First Name:

Select Service Address

Capture	Provider	Vendor
Provider ID	Last Name	Vendor ID
Tax ID	First Name	Vendor Last Name
Alternate ID	Service Address	Paid To Vendor ID
		Pay To Address
<input type="radio"/>	676767 ILLINOIS TRAINING	D161742 ILLINOIS TRAINING
	361234567 123 TRAINING AVE CHICAGO, IL 60290-	123 TRAINING AVE CHICAGO, IL 60290-

Back Next

© 2010 ValueOptions® ProviderConnect v3.17.00

18. Select service address

19. Click the Next tab

20. Provider will be taken to the Requested Services Header

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): 11292010
 *Level of Service: OUTPATIENT

*Type of Service: MENTAL HEALTH
 *Level of Care: COMMUNITY SUPPORT GROUP

Provider			
Tax ID	Provider ID	Provider Last Name	Vendor ID
361234567	676767	ILLINOIS TRAINING	D161742

Consumer			
Consumer ID	Last Name	First Name	Date of Birth (MMDDYYYY)
ILLTEST99	MEMBER99	TEST	01011980

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 Consumer? Yes No

*Document Description: SELECT...
 UploadFile Click to attach a document Delete Click to delete an attached document

Attached Document:

Back Next

21. Enter a Requested Start Date for the start date of the authorization

22. Enter Level of Service = Outpatient

23. Enter Type of Service = Mental Health

24. Enter Level of Care = Community Support Group

25. If provider wishes to attach all required supporting documentation (MHA, ITP, additional documents supporting medical necessity), click the **+** button to the right of **Document Type+**
26. Select appropriate document from list in drop down menu in **Document Description+**
27. Click the **Upload+** tab
28. Upload each document following steps 25, 26, and 27
29. Click **Next+**
30. Provider will be taken to the **Requested Services Header+** screen



[ProviderConnect Home](#)

DIAGNOSIS
ASSESSMENTS
TRANSITION OR DISCHARGE PLAN
RESULTS

PAGE 1 of 4

Requested Services Header

Requested Start Date 11/29/2010	Consumer Name MEMBER99, TEST	Provider Name ILLINOIS TRAINING,	Vendor ID D161742	Save Request as Draft
Type of Request INITIAL	Consumer ID ILLTEST99	Provider ID 676767	NPI # for Authorization SELECT...	
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Community Support Group	Type of Care	Authorized User

Date Therapy/ Counseling, Community Support Group or Psychosocial Rehabilitation Started:

Clinical Staff to Contact if questions: Phone # Ext. Fax #

Encrypted Email address:

Diagnosis

Please re-register the consumer if any of the displayed diagnosis information has changed since the last time you registered the consumer.
Please indicate primary diagnosis.

<h4>Axis I</h4> <table border="0" style="width: 100%;"> <tr><td>*Diagnosis Code 1</td><td>Description</td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td>Diagnosis Code 2</td><td>Description</td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td>Diagnosis Code 3</td><td>Description</td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </table>	*Diagnosis Code 1	Description	<input type="text"/>	<input type="text"/>	Diagnosis Code 2	Description	<input type="text"/>	<input type="text"/>	Diagnosis Code 3	Description	<input type="text"/>	<input type="text"/>	<h4>Axis II</h4> <table border="0" style="width: 100%;"> <tr><td>*Diagnosis Code 1</td><td>Description</td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td>Diagnosis Code 2</td><td>Description</td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td>Diagnosis Code 3</td><td>Description</td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </table>	*Diagnosis Code 1	Description	<input type="text"/>	<input type="text"/>	Diagnosis Code 2	Description	<input type="text"/>	<input type="text"/>	Diagnosis Code 3	Description	<input type="text"/>	<input type="text"/>
*Diagnosis Code 1	Description																								
<input type="text"/>	<input type="text"/>																								
Diagnosis Code 2	Description																								
<input type="text"/>	<input type="text"/>																								
Diagnosis Code 3	Description																								
<input type="text"/>	<input type="text"/>																								
*Diagnosis Code 1	Description																								
<input type="text"/>	<input type="text"/>																								
Diagnosis Code 2	Description																								
<input type="text"/>	<input type="text"/>																								
Diagnosis Code 3	Description																								
<input type="text"/>	<input type="text"/>																								
<h4>Axis III</h4> <p>*Diagnosis Code 1 SELECT...</p>	<h4>Axis IV</h4> <p><i>Check all that apply</i></p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> Problems with access to health care services</td> </tr> <tr> <td><input type="checkbox"/> Educational problems</td> <td><input type="checkbox"/> Problems related to interaction w/legal system/crime</td> </tr> <tr> <td><input type="checkbox"/> Financial problems</td> <td><input type="checkbox"/> Problems with Primary support group</td> </tr> <tr> <td><input type="checkbox"/> Housing problems</td> <td><input type="checkbox"/> Problems related to the social environment</td> </tr> <tr> <td><input type="checkbox"/> Occupational problems</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Other psychosocial and environmental problems</td> <td></td> </tr> </table>	<input type="checkbox"/> None	<input type="checkbox"/> Problems with access to health care services	<input type="checkbox"/> Educational problems	<input type="checkbox"/> Problems related to interaction w/legal system/crime	<input type="checkbox"/> Financial problems	<input type="checkbox"/> Problems with Primary support group	<input type="checkbox"/> Housing problems	<input type="checkbox"/> Problems related to the social environment	<input type="checkbox"/> Occupational problems	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other psychosocial and environmental problems													
<input type="checkbox"/> None	<input type="checkbox"/> Problems with access to health care services																								
<input type="checkbox"/> Educational problems	<input type="checkbox"/> Problems related to interaction w/legal system/crime																								
<input type="checkbox"/> Financial problems	<input type="checkbox"/> Problems with Primary support group																								
<input type="checkbox"/> Housing problems	<input type="checkbox"/> Problems related to the social environment																								
<input type="checkbox"/> Occupational problems	<input type="checkbox"/> Unknown																								
<input type="checkbox"/> Other psychosocial and environmental problems																									
<h4>Axis V</h4> <p>Diagnosis Code 2 SELECT...</p>																									
<p>Current GAF Score <input type="text"/></p> <p>Current CGAS Score <input type="text"/></p>	<p>Highest GAF Score in the Past Year <input type="text"/></p> <p>Highest CGAS Score in the Past Year <input type="text"/></p>																								

Psychotropic Medications

<p>1. Medication <u>Description</u></p> <p>_____</p> <p>Dosage _____ Frequency <u>SELECT...</u></p> <p>Is medication found to be effective? <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A</p>	<p>Side effects?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Usually adherent?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Prescriber <u>SELECT...</u></p>
<p>2. Medication <u>Description</u></p> <p>_____</p> <p>Dosage _____ Frequency <u>SELECT...</u></p> <p>Is medication found to be effective? <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A</p>	<p>Side effects?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Usually adherent?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Prescriber <u>SELECT...</u></p>
<p>3. Medication <u>Description</u></p> <p>_____</p> <p>Dosage _____ Frequency <u>SELECT...</u></p> <p>Is medication found to be effective? <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A</p>	<p>Side effects?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Usually adherent?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Prescriber <u>SELECT...</u></p>
<p>4. Medication <u>Description</u></p> <p>_____</p> <p>Dosage _____ Frequency <u>SELECT...</u></p> <p>Is medication found to be effective? <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A</p>	<p>Side effects?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Usually adherent?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Prescriber <u>SELECT...</u></p>

Back Next

© 2010 ValueOptions® ProviderConnect v3.17.00

31. Provider will complete all required fields.

32. Click the **Next** tab

33. Provider will be taken to the **LOCUS Results** Screen. ***If the consumer is 18 or older, this information is required.

Requested Services Header

Requested Start Date 12/01/2010	Consumer Name MEMBER99, TEST	Provider Name ILLINOIS TRAINING,	Vendor ID D161742	<input type="button" value="Save Request as Draft"/>
Type of Request INITIAL	Consumer ID ILLTEST99	Provider ID 676767	NPI # for Authorization <input type="button" value="SELECT..."/>	
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Community Support Group	Type of Care	Authorized User <input type="text"/>

LOCUS Results

Please re-register the consumer if any of the displayed LOCUS information has changed since the last time you registered the consumer.

Functional Impairment Domain Scores		Note: Locus Results information should be populated for Adult Consumers.	
Risk of Harm	<input type="text" value="2"/>	Recovery Environment - Environmental Stressors	<input type="text" value="2"/>
Functional Status	<input type="text" value="2"/>	Recovery Environment - Environmental Support	<input type="text" value="3"/>
Co-morbidity	<input type="text" value="1"/>	Recovery And Treatment History	<input type="text" value="2"/>
		Acceptance and Engagement	<input type="text" value="3"/>
Composite Score	<input type="text" value="15"/>		

LOCUS Recommended Level of Care

Reason for Deviation

Assessor Recommended Level of Care

(of 200)

34. Complete %Functional Impairment Domain Scores+
35. Select %LOCUS Recommended Level of Care+
36. Select %Assessor Recommended Level of Care+
37. Provide narrative explanation of any %Reason for Deviation+in appropriate text box

38. If the consumer is less than 18 years old, the Ohio Scale or Devereaux Scale Results must be completed.
- For youth ages 5-17, the Ohio Scale is required
 - For children under the age of 5 and under, the DECA Subscale is required

Ohio Scale Results

Worker Ohio Problem Severity Scale Score (For youth age 5 - 17) (0-100)

Admission (all) Current (if in treatment more than 90 days)

Devereaux Scale Results

DECA Subscale (For children under the age of 3)

Protective Factor Scores

Admission (all) % Current (if in treatment more than 90 days) %

DECA Subscale (For children over the age of 3, under the age of 5)

Protective Factor Scores

Admission (all) % Current (if in treatment more than 90 days) %

Behavioral Concerns

Admission (all) % Current (if in treatment more than 90 days) %

39. At the bottom of the page, indicate whether the required documents will be attached, faxed, or not applicable for each item.

Required Documents

All required supporting documents for this request, including the Mental Health Assessment and Individual Treatment Plan, must either be attached as "secure clinical" documents to this application or faxed to the Collaborative (at 866-928-7177) within one business day of this request submission. Should the required documents not be faxed to the Collaborative within one business day, the request will not be considered for processing. The provider will be required to submit a new request for authorization.

Attached	Faxed	N/A	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health Assessment dated within the past year.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Individual Treatment Plan dated within past six months.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health Assessment Update, if indicated.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other clinical documentation supporting medical necessity.

40. Click the **Next** tab
41. Provider will be taken to the **Services Requested** screen


ProviderConnect Home

DIAGNOSIS ASSESSMENTS TRANSITION OR DISCHARGE PLAN RESULTS

PAGE 3 of 4

Requested Services Header

Requested Start Date 11/29/2010	Consumer Name MEMBER99, TEST	Provider Name ILLINOIS TRAINING,	Vendor ID D161742	<input type="button" value="Save Request as Draft"/>
Type of Request INITIAL	Consumer ID ILLTEST99	Provider ID 676767	NPI # for Authorization <input type="button" value="SELECT..."/>	
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Community Support Group	Type of Care	Authorized User <input type="text"/>

Services Requested

<input checked="" type="checkbox"/> Community Support Group	Start Date <input type="text" value="11292010"/>	End Date <input type="text" value="12222010"/>	Number of Units <input type="text" value="20"/>
---	---	---	--

Transition or Discharge Plan

* Is there a written plan to facilitate the consumer's transition to alternative services or to terminate service provision altogether? Yes No

* Has the consumer/guardian been involved in the discharge/transition planning? Yes No

* If the consumer will transition to alternative services, have treatment resources been identified and contacts made to coordinate discharge/transition planning? Yes No N/A

© 2010 ValueOptions® ProviderConnect v3.17.00

Consumer/guardian/family not engaged/participating in care or transition planning

* Describe plan to overcome barriers to discharge:
Please provide updates for ongoing requests, as needed.

© 2010 ValueOptions® ProviderConnect v3.17.00

42. Indicate %Start Date+, %End Date+, and %Number of Units+requested
43. Complete %Transition or Discharge Plan Section+, providing required narrative.
44. Click the %Submit+tab
45. Provider will be taken to the %Determination Status+Screen

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 consumer's authorization history.

Consumer Name ILLTEST MEMBER01	Consumer ID ILLTEST01	Consumer DOB 01/01/1980	Subscriber Name ILLTEST MEMBER01	Subscriber ID ILLTEST01
Pended Authorization # 091810-3-40	Client Authorization # N/A	Type of Request CONCURRENT		
Date of Admission/ Start of Services 11/08/2010	Requested From 11/08/2010	Submission Date 11/17/2010		
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service MENTAL HEALTH	Level of Care COMMUNITY SUPPORT	Type of Care	
Reason Code P76				

Attached Documents

There are no documents attached with this Authorization Request

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

Authorization Printing & Downloading Options:

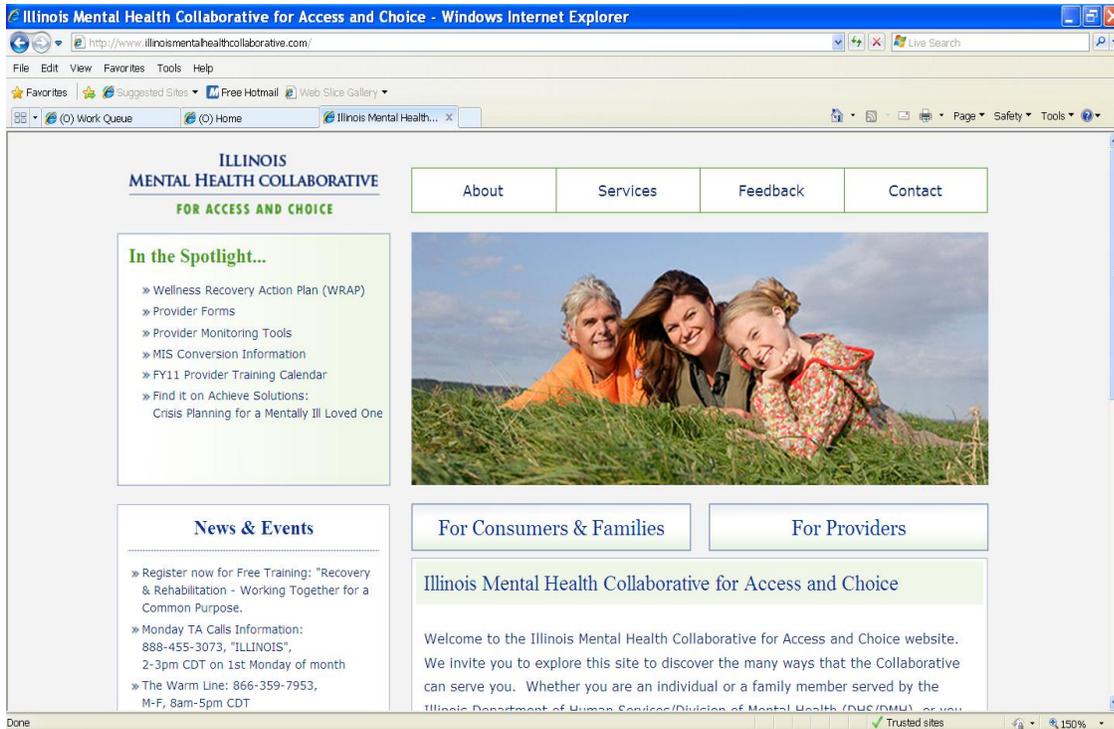
(For the best print results, please print in 'Landscape' format)

Print Authorization Result <i>Print the Results page (this page)</i>	Print Authorization Request <i>Print the entire Authorization Request</i>	Download Authorization Request <i>Download the entire Authorization Request</i>	Return to Provider Home <i>Return to the ProviderConnect homepage</i>
---	--	--	--

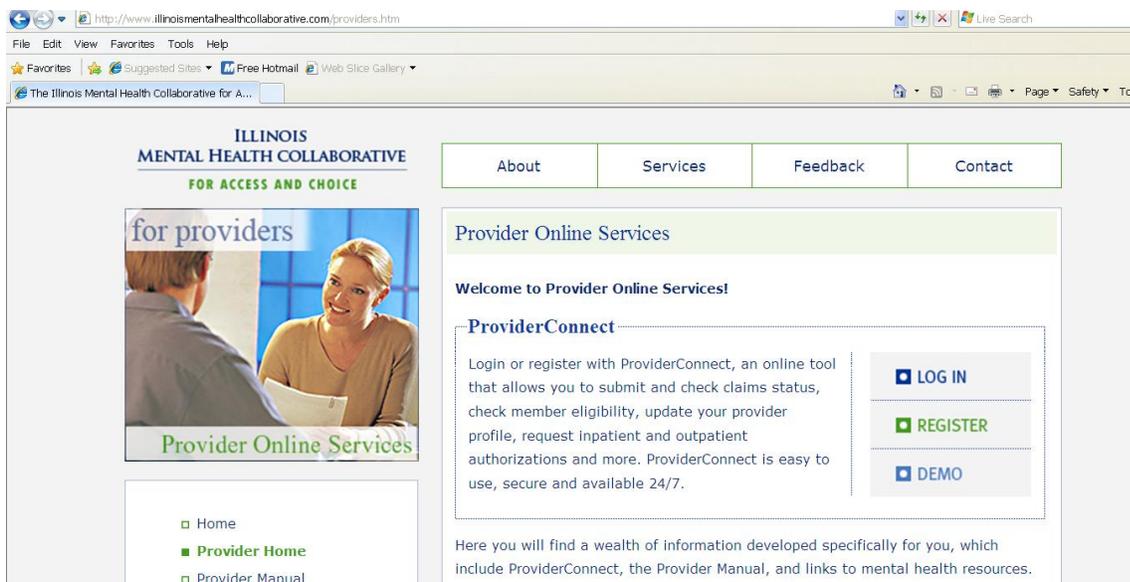
46. Provider can choose to:
- a. Print the Authorization Result
 - b. Print the Authorization Request
 - c. Download the Authorization Request
 - d. Return to Provider Home

Electronic Submission Process for Psychosocial Rehabilitation (PSR)

1. Go to Illinois Mental Health Collaborative website:
<http://www.illinoismentalhealthcollaborative.com>



2. Once at the homepage, click the **For Providers** tab



3. Click the **Log In** tab
4. Enter User ID

5. Enter Password
6. Click the %Log In tab+

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

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

*Password

[Forgot Your Password?](#)

Log In

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.

7. Provider will see the Use Agreement

ProviderConnect Use Agreement

Welcome to www.valueoptions.com, the website for ValueOptions, Inc.

Please carefully read the terms of this Agreement before you click the "I Agree" button. If, after reading the terms you agree on behalf of yourself and your company or organization or facility to be bound by this Agreement, you must click the "I Agree" button at the end of this screen in order to proceed

By clicking the "I Agree" button and accessing or using the ProviderConnect site or any of the online services available, you, on behalf of yourself and your company or organization or facility: (1) represent and warrant that you have the capacity and authority to enter into this Agreement; (2) agree to be bound by the terms and conditions of this Agreement; and (3) acknowledge and agree all transactions and services conducted through ProviderConnect are and carry full legal authority as if same were transacted or conducted on paper. You will need to request a user name and password for access to certain online services available on ProviderConnect.

If you do not wish to be bound by the terms and conditions of this Agreement, or do not have the legal authority to enter into this Agreement, you may not proceed or use any of the transactions or services available on ProviderConnect.

This ProviderConnect Use Agreement (the "Agreement") is between you and ValueOptions, Inc. on behalf of itself and its affiliates and subsidiaries ("ValueOptions®") and governs your use of ProviderConnect. By accessing the ProviderConnect site or using any of the online services available, you agree to the following terms:

Provider Agreement. If you or your company, organization or facility have a participation or facility agreement in effect with ValueOptions, your use of ProviderConnect and any online transactions or services accessed thereunder is also subject to the terms and conditions of that provider agreement. If you or your company, organization or facility do not have a participation or facility agreement in effect with ValueOptions, your use of ProviderConnect and any online transactions or services accessed there under are subject to the terms of this Agreement.

8. At the bottom of this page, provider will see tabs indicating agreement or disagreement.

and/or your use or misuse of ProviderConnect and/or any online transactions or services available thereunder and/or information contained within or transmitted through ProviderConnect by you or your authorized designee.

Updates & Modifications. ValueOptions, in its sole discretion, may update or modify this Agreement from time to time. ValueOptions will provide notice of updates or modifications to this Agreement on this website. If you continue to use or access the ProviderConnect site following such notice, you are deemed to have accepted the updated or modified Agreement and agreed to all of the terms and conditions contained therein. This Agreement is available on the ProviderConnect site. You agree to review this Agreement periodically.

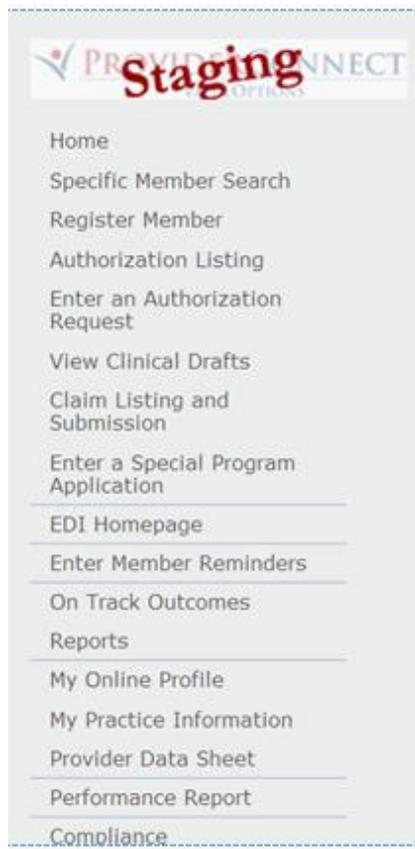
Assignment & Governing Law. You may assign this Agreement only with the prior written consent of ValueOptions. This Agreement and all disputes, lawsuits and claims relating to this Agreement shall be governed by the laws of the Commonwealth of Virginia, excluding its conflicts of law rules.

Termination. You may terminate this Agreement by providing written notice to ValueOptions and discontinuing your use of ProviderConnect. ValueOptions may terminate this Agreement and your right to access or use ProviderConnect at any time, with or without cause.

676767
ILLINOIS TRAINING
123 TRAINING AVE
CHICAGO, IL 60290

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

9. If provider wishes to continue with the process, provider will click the %Agree+ tab. The provider will be taken to the ProviderConnect home page and will select %Specific Member Search+from the options on the left hand side of the page.



10. Provider will be taken to the %Eligibility and Benefits Search+screen.
11. Enter required fields: Member ID (9 digit RIN) and Date of Birth
12. Click %Search+tab

Staging PROVIDERCONNECT

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
 Enter a Special Program Application
 EDI Homepage
 Enter Member Reminders
 On Track Outcomes
 Reports
 My Online Profile
 My Practice Information
 Provider Data Sheet
 Performance Report
 Compliance

Eligibility & Benefits Search

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 11162010 (MMDDYYYY)

13. Provider will be taken to the %Demographics+screen for the consumer
14. Click the %Enter an Authorization Request+tab at the left hand side of the screen

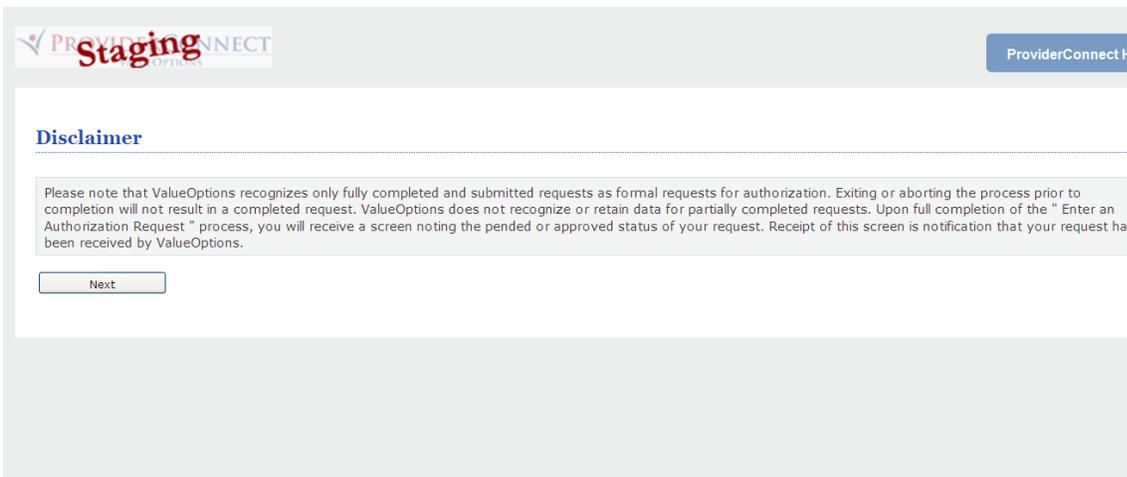
Staging PROVIDERCONNECT

Demographics Enrollment History COB Benefits Additional Information

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

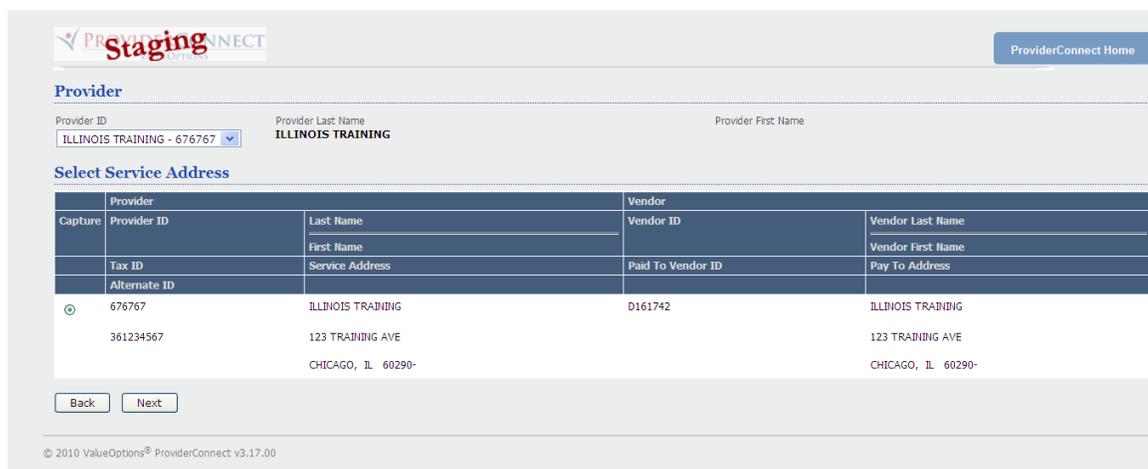
Consumer?		Eligibility
Consumer ID	ILLTEST01	Effective Date
Alternate ID		Expiration Date
Consumer Name	MEMBER01, ILLTEST	COB Effective Date?
Date of Birth	01/01/1980	View Funding Source Enrollment De
Address	1 TEST DRIVE APT 2D CHICAGO, IL 60608	
Alternate Address		Subscriber
Marital Status	-	Subscriber ID
Home Phone		Subscriber Name

15. Provider will be taken to the %Disclaimer+page



16. If provider wishes to proceed with authorization request, they will click the %Next+ tab

17. Provider will be taken to the %Provider+ screen



18. Select service address

19. Click the %Next+ tab

20. Provider will be taken to the %Requested Services Header+ page

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

Provider

Tax ID	Provider ID	Provider Last Name	Vendor ID
361234567	676767	ILLINOIS TRAINING	D161742

Consumer

Consumer ID	Last Name	First Name	Date of Birth (MMDDYYYY)
ILLTEST99	MEMBER99	TEST	01011980

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: Yes No

*Document Description:

Click to attach a document Click to delete an attached document

Attached Document:

21. Enter a %Requested Start Date+ for the start date of the authorization
22. Enter %Level of Service+= %Outpatient+
23. Enter %Type of Service+= %Mental Health+
24. Enter %Level of Care+= %Psychosocial Rehabilitation+
25. If provider wishes to attach all required supporting documentation (MHA, ITP, additional documents supporting medical necessity), click the %Yes+ button to the right of %Document Type+
26. Select appropriate document from list in drop down menu in %Document Description+
27. Click the %Upload+ tab
28. Upload each document following steps 25, 26, and 27
29. Click %Next+
30. Provider will be taken to the %Requested Services Header+ screen

Requested Services Header

Requested Start Date 12/01/2010	Consumer Name MEMBER99, TEST	Provider Name ILLINOIS TRAINING,	Vendor ID D161742	<input type="button" value="Save Request as Draft"/>
Type of Request CONCURRENT	Consumer ID ILLTEST99	Provider ID 676767	NPI # for Authorization <input type="text" value="SELECT..."/>	
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Psychosocial Rehabilitation	Type of Care	Authorized User <input type="text"/>

Date Therapy/ Counseling, Community Support Group or Psychosocial Rehabilitation Started:

Clinical Staff to Contact if questions

Phone # Ext

Fax #

Encrypted Email address

Diagnosis

Please re-register the consumer if any of the displayed diagnosis information has changed since the last time you registered the consumer.
Please indicate primary diagnosis.

Axis I

Diagnosis Code 1 Description

Diagnosis Code 2 Description

Axis II

Diagnosis Code 1 Description

Diagnosis Code 2 Description

<input checked="" type="checkbox"/> Financial problems	<input checked="" type="checkbox"/> Problems with Primary support group
<input checked="" type="checkbox"/> Housing problems	<input checked="" type="checkbox"/> Problems related to the social environment
<input checked="" type="checkbox"/> Occupational problems	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other psychosocial and environmental problems	

Diagnosis Code 2

Axis V

Current GAF Score Highest GAF Score in the Past Year

Psychotropic Medications

<p><u>1. Medication</u> <u>Description</u> <input type="text" value="ABILIF"/> <input type="text" value="Abilify (Aripiprazole)"/></p> <p>Dosage <input type="text"/> Frequency <input type="text" value="SELECT..."/></p> <p><u>Is medication found to be effective?</u> <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A</p>	<p>Side effects? <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Usually adherent? <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Prescriber <input type="text" value="SELECT..."/></p>
<p><u>2. Medication</u> <u>Description</u> <input type="text" value="PAXIL"/> <input type="text" value="Paxil (Paroxetine)"/></p> <p>Dosage <input type="text"/> Frequency <input type="text" value="SELECT..."/></p> <p><u>Is medication found to be effective?</u> <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A</p>	<p>Side effects? <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Usually adherent? <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Prescriber <input type="text" value="SELECT..."/></p>
<p><u>3. Medication</u> <u>Description</u> <input type="text"/> <input type="text"/></p> <p>Dosage <input type="text"/> Frequency <input type="text" value="SELECT..."/></p> <p><u>Is medication found to be effective?</u> <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A</p>	<p>Side effects? <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Usually adherent? <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Prescriber <input type="text" value="SELECT..."/></p>
<p><u>4. Medication</u> <u>Description</u> <input type="text"/> <input type="text"/></p> <p>Dosage <input type="text"/> Frequency <input type="text" value="SELECT..."/></p> <p><u>Is medication found to be effective?</u> <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A</p>	<p>Side effects? <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Usually adherent? <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Prescriber <input type="text" value="SELECT..."/></p>

31. Provider will complete all required fields.
32. Click the %Next+tab
33. Provider will be taken to the %LOCUS Results+Screen.

Requested Services Header

Requested Start Date 12/01/2010	Consumer Name MEMBER99, TEST	Provider Name ILLINOIS TRAINING,	Vendor ID D161742	<input type="button" value="Save Request as Draft"/>
Type of Request CONCURRENT	Consumer ID ILLTEST99	Provider ID 676767	NPI # for Authorization <input type="button" value="SELECT..."/>	
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Psychosocial Rehabilitation	Type of Care <input type="text" value="Authorized User"/>	

LOCUS Results

Please re-register the consumer if any of the displayed LOCUS information has changed since the last time you registered the consumer.

Functional Impairment Domain Scores **Note: LOCUS Results information should be populated for Adult Consumers.**

Risk of Harm	<input type="text" value="2"/>	Recovery Environment - Environmental Stressors	<input type="text" value="1"/>
Functional Status	<input type="text" value="3"/>	Recovery Environment - Environmental Support	<input type="text" value="2"/>
Co-morbidity	<input type="text" value="3"/>	Recovery And Treatment History	<input type="text" value="4"/>
Composite Score	<input type="text" value="16"/>	Acceptance and Engagement	<input type="text" value="1"/>

LOCUS Recommended Level of Care

Assessor Recommended Level of Care

Reason for Deviation

(of 200)

34. Complete %Functional Impairment Domain Scores+
35. Select %LOCUS Recommended Level of Care+
36. Select %Assessor Recommended Level of Care+
37. Provide narrative explanation of any %Reason for Deviation+in appropriate text box

LOCUS Recommended Level of Care

Assessor Recommended Level of Care

Reason for Deviation

(of 200)

Required Documents

All required supporting documents for this request, including the Mental Health Assessment and Individual Treatment Plan, must either be attached as "secure clinical" documents to this application or faxed to the Collaborative (at 866-928-7177) within one business day of this request submission. Should the required documents not be faxed to the Collaborative within one business day, the request will not be considered for processing. The provider will be required to submit a new request for authorization.

Attached	Faxed	N/A	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health Assessment dated within the past year.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Individual Treatment Plan dated within past six months.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health Assessment Update, if indicated.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other clinical documentation supporting medical necessity.

38. At the bottom of the page, indicate whether the required documents will be attached, faxed, or not applicable for each item.

39. Click the **Next** tab

40. Provider will be taken to the **Services Requested** screen

DIAGNOSIS ASSESSMENTS **TRANSITION OR DISCHARGE PLAN** RESULTS

PAGE 3 of 4

Requested Services Header

Requested Start Date 12/01/2010	Consumer Name MEMBER99, TEST	Provider Name ILLINOIS TRAINING,	Vendor ID D161742	<input type="button" value="Save Request as Draft"/>
Type of Request CONCURRENT	Consumer ID ILLTEST99	Provider ID 676767	NPI # for Authorization SELECT...	
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Psychosocial Rehabilitation	Type of Care	Authorized User

Services Requested

<input checked="" type="checkbox"/> Psychosocial Rehabilitation	Start Date 12012010	End Date 01122011	Number of Units 20
---	-------------------------------	-----------------------------	------------------------------

Transition or Discharge Plan

* Is there a written plan to facilitate the consumer's transition to alternative services or to terminate service provision altogether? Yes No

* Has the consumer/guardian been involved in the discharge/transition planning? Yes No

* If the consumer will transition to alternative services, have treatment resources been identified and contacts made to coordinate discharge/transition planning? Yes No N/A

If yes, please provide the following information:

Provider Name	Appointment Date	Services Planned
<input type="text"/>	<input type="text"/>	<input type="text"/>
Provider Name	Appointment Date	Services Planned
<input type="text"/>	<input type="text"/>	<input type="text"/>

* How many days until anticipated discharge or transition to alternative services? **15**

* If the consumer will not need continuing services, have natural community supports been identified and has the consumer been assisted in accessing them? Yes No N/A

* Does the individual have a current Crisis Plan and understand how to access the services and supports included in it? Yes No N/A

* Barriers to Discharge
Check all that apply.

- Consumer is not meeting criteria for lower level of care or discharge
- Transitional services not identified or not available
- Community resources not identified or difficult to obtain
- Consumer/guardian/family not engaged/participating in care or transition planning

* Describe plan to overcome barriers to discharge:
Please provide updates for ongoing requests, as needed.

▼ Narrative History

VIWSSO 112910, 15:51:31 ET
test test test test test

▼ Narrative Entry (24 of 250)

test test test test test

© 2010 ValueOptions® ProviderConnect v3.17.00

41. Indicate **Start Date**, **End Date**, and **Number of Units** requested

42. Complete **Transition or Discharge Plan Section**, providing required narrative.

43. Click the **Submit** tab

44. Provider will be taken to the **Determination Status** Screen

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 consumer's authorization history.

Consumer Name	Consumer ID	Consumer DOB	Subscriber Name	Subscriber ID
ILLTEST MEMBER01	ILLTEST01	01/01/1980	ILLTEST MEMBER01	ILLTEST01

Pended Authorization #	Client Authorization #	Type of Request
091810-4-14	N/A	CONCURRENT

Date of Admission/ Start of Services	Requested From	Submission Date
11/01/2010	11/01/2010	11/17/2010

Level of Service	Type of Service	Level of Care	Type of Care
OUTPATIENT/COMMUNITY BASED	MENTAL HEALTH	PSYCHOSOCIAL REHABILITATION	

Reason Code
P76

Provider Name & Address	Provider ID	NPI # for Authorization
ILLINOIS TRAINING 123 TRAINING AVE CHICAGO IL 60290	676767	N/A

Message

P76

Attached Documents There are no documents attached with this Authorization Request

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

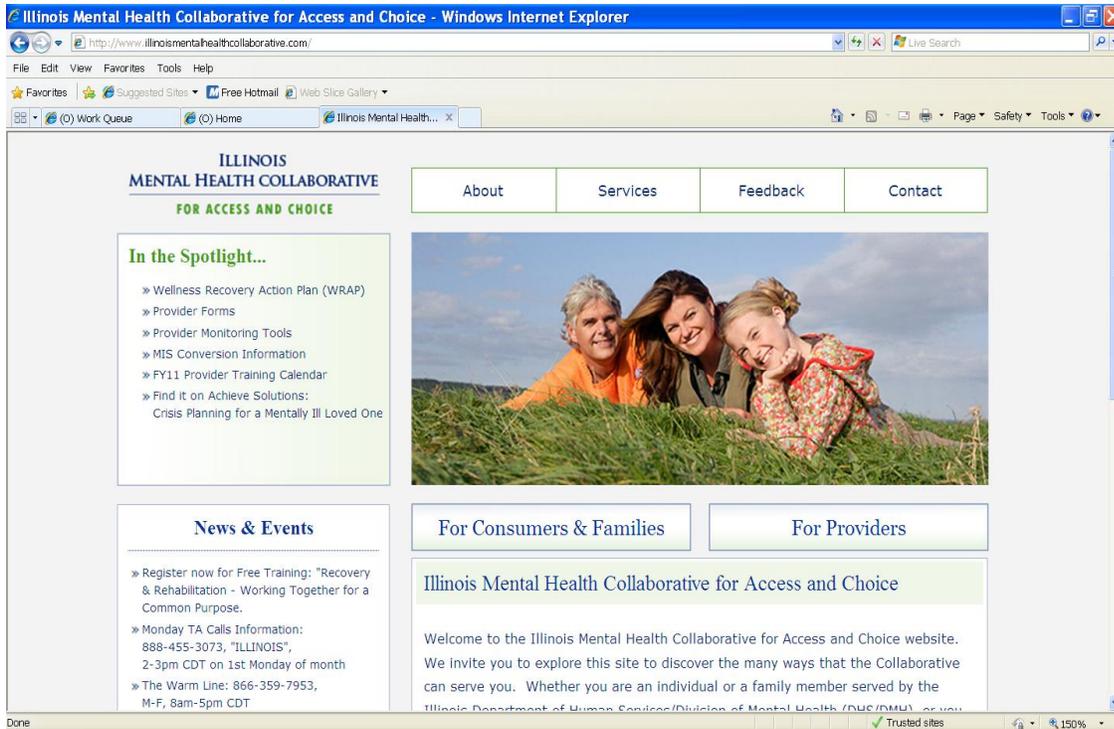
Authorization Printing & Downloading Options:
(For the best print results, please print in 'Landscape' format)

- | | | | |
|---|--|--|--|
| Print Authorization Result
<i>Print the Results page (this page)</i> | Print Authorization Request
<i>Print the entire Authorization Request</i> | Download Authorization Request
<i>Download the entire Authorization Request</i> | Return to Provider Home
<i>Return to the ProviderConnect homepage</i> |
|---|--|--|--|

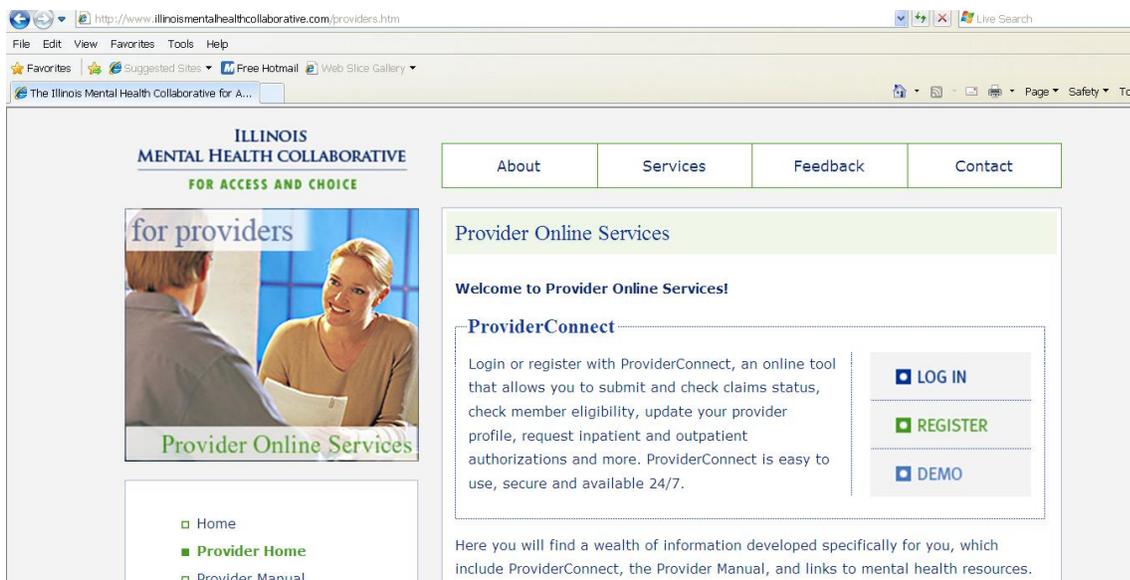
45. Provider can choose to:
- a. Print the Authorization Result
 - b. Print the Authorization Request
 - c. Download the Authorization Request
 - d. Return to Provider Home

Electronic Submission Process for Therapy/Counseling (T/C)

1. Go to Illinois Mental Health Collaborative website:
<http://www.illinoismentalhealthcollaborative.com>



2. Once at the homepage, click the **For Providers** tab



3. Click the **Log In** tab
4. Enter User ID

5. Enter Password
6. Click the %log In tab+

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

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

*Password

[Forgot Your Password?](#)

Log In

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.

7. Provider will see the Use Agreement

ProviderConnect Use Agreement

Welcome to www.valueoptions.com, the website for ValueOptions, Inc.

Please carefully read the terms of this Agreement before you click the "I Agree" button. If, after reading the terms you agree on behalf of yourself and your company or organization or facility to be bound by this Agreement, you must click the "I Agree" button at the end of this screen in order to proceed

By clicking the "I Agree" button and accessing or using the ProviderConnect site or any of the online services available, you, on behalf of yourself and your company or organization or facility: (1) represent and warrant that you have the capacity and authority to enter into this Agreement; (2) agree to be bound by the terms and conditions of this Agreement; and (3) acknowledge and agree all transactions and services conducted through ProviderConnect are and carry full legal authority as if same were transacted or conducted on paper. You will need to request a user name and password for access to certain online services available on ProviderConnect.

If you do not wish to be bound by the terms and conditions of this Agreement, or do not have the legal authority to enter into this Agreement, you may not proceed or use any of the transactions or services available on ProviderConnect.

This ProviderConnect Use Agreement (the "Agreement") is between you and ValueOptions, Inc. on behalf of itself and its affiliates and subsidiaries ("ValueOptions®") and governs your use of ProviderConnect. By accessing the ProviderConnect site or using any of the online services available, you agree to the following terms:

Provider Agreement. If you or your company, organization or facility have a participation or facility agreement in effect with ValueOptions, your use of ProviderConnect and any online transactions or services accessed thereunder is also subject to the terms and conditions of that provider agreement. If you or your company, organization or facility do not have a participation or facility agreement in effect with ValueOptions, your use of ProviderConnect and any online transactions or services accessed there under are subject to the terms of this Agreement.

8. At the bottom of this page, provider will see tabs indicating agreement or disagreement.

and/or your use or misuse of ProviderConnect and/or any online transactions or services available thereunder and/or information contained within or transmitted through ProviderConnect by you or your authorized designee.

Updates & Modifications. ValueOptions, in its sole discretion, may update or modify this Agreement from time to time. ValueOptions will provide notice of updates or modifications to this Agreement on this website. If you continue to use or access the ProviderConnect site following such notice, you are deemed to have accepted the updated or modified Agreement and agreed to all of the terms and conditions contained therein. This Agreement is available on the ProviderConnect site. You agree to review this Agreement periodically.

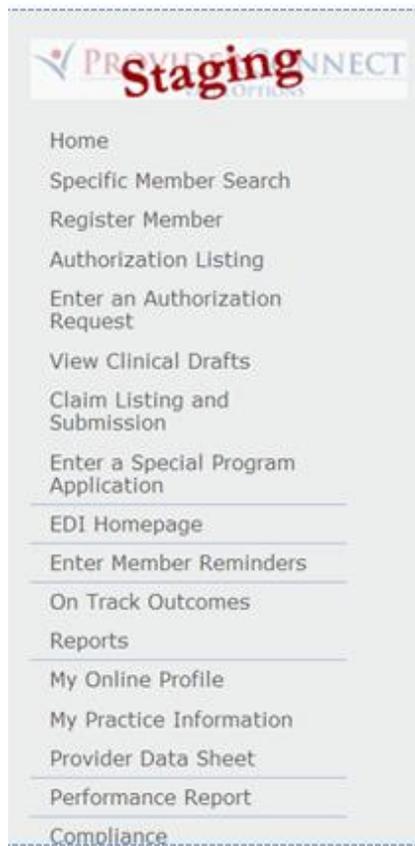
Assignment & Governing Law. You may assign this Agreement only with the prior written consent of ValueOptions. This Agreement and all disputes, lawsuits and claims relating to this Agreement shall be governed by the laws of the Commonwealth of Virginia, excluding its conflicts of law rules.

Termination. You may terminate this Agreement by providing written notice to ValueOptions and discontinuing your use of ProviderConnect. ValueOptions may terminate this Agreement and your right to access or use ProviderConnect at any time, with or without cause.

676767
ILLINOIS TRAINING
123 TRAINING AVE
CHICAGO, IL 60290

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

9. If provider wishes to continue with the process, provider will click the %o Agree+tab. The provider will be taken to the ProviderConnect home page and will select %s Specific Member Search+from the options on the left hand side of the page.



10. Provider will be taken to the %e Eligibility and Benefits Search+screen.
11. Enter required fields: Member ID (9 digit RIN) and Date of Birth
12. Click %s Search+tab

PROVIDERCONNECT Staging

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
 Enter a Special Program Application
 EDI Homepage
 Enter Member Reminders
 On Track Outcomes
 Reports
 My Online Profile
 My Practice Information
 Provider Data Sheet
 Performance Report
 Compliance

Eligibility & Benefits Search

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 11162010 (MMDDYYYY)

13. Provider will be taken to the %Demographics+screen for the consumer
14. Click the %Enter an Authorization Request+tab at the left hand side of the screen

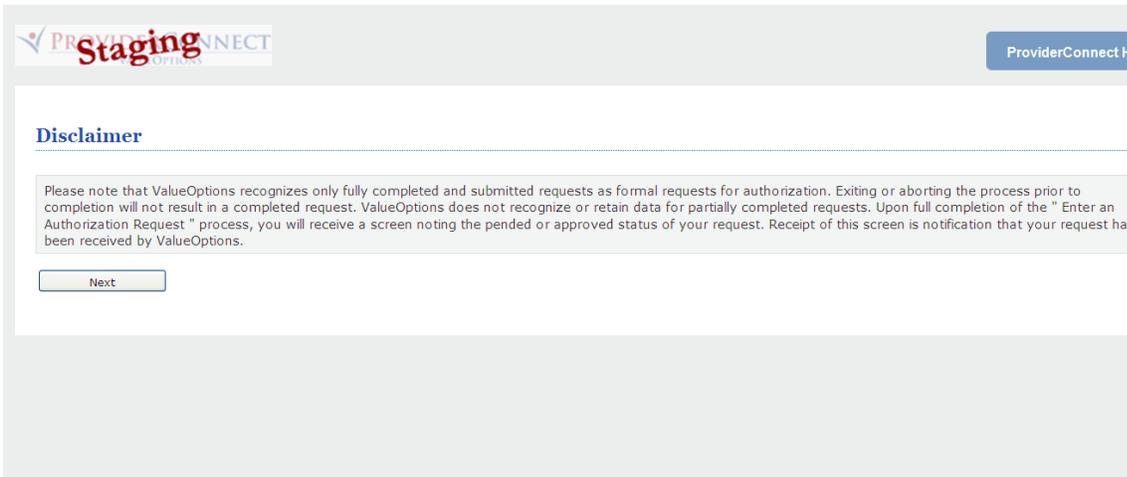
PROVIDERCONNECT Staging

Demographics Enrollment History COB Benefits Additional Information

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

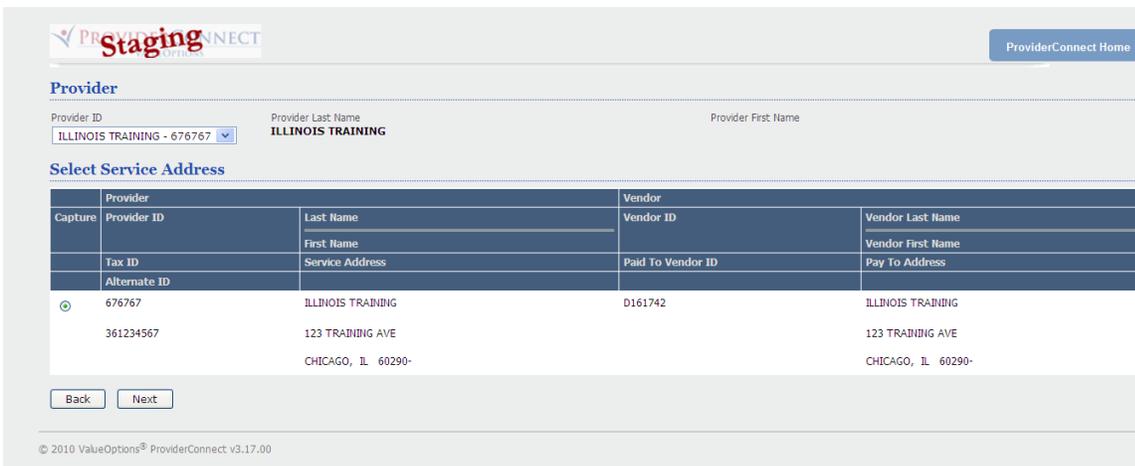
Consumer?		Eligibility
Consumer ID	ILLTEST01	Effective Date
Alternate ID		Expiration Date
Consumer Name	MEMBER01, ILLTEST	COB Effective Date [?]
Date of Birth	01/01/1980	View Funding Source Enrollment De
Address	1 TEST DRIVE APT 2D CHICAGO, IL 60608	
Alternate Address		Subscriber
Marital Status	-	Subscriber ID
Home Phone		Subscriber Name

15. Provider will be taken to the %Disclaimer+page



16. If provider wishes to proceed with authorization request, they will click the **Next** tab

17. Provider will be taken to the **Provider** screen



18. Select service address

19. Click the **Next** tab

20. Provider will be taken to the **Requested Services Header**

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

Provider

Tax ID	Provider ID	Provider Last Name	Vendor ID
361234567	676767	ILLINOIS TRAINING	D161742

Consumer

Consumer ID	Last Name	First Name	Date of Birth (MMDDYYYY)
ILLTEST99	MEMBER99	TEST	01011980

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 Consumer? Yes No

*Document Description:

21. Enter a **Requested Start Date** for the start date of the authorization
22. Enter **Level of Service** = **Outpatient**
23. Enter **Type of Service** = **Mental Health**
24. Enter **Level of Care** = **Therapy/Counseling**
25. If provider wishes to attach all required supporting documentation (MHA, ITP, additional documents supporting medical necessity), click the **Yes** button to the right of **Document Type**
26. Select appropriate document from list in drop down menu in **Document Description**
27. Click the **Upload** tab
28. Upload each document following steps 25, 26, and 27
29. Click **Next**

30. Provider will be taken to the Requested Services Header screen



[ProviderConnect Home](#)

DIAGNOSIS
ASSESSMENTS
TRANSITION OR DISCHARGE PLAN
RESULTS

PAGE 1 of 4

Requested Services Header

Requested Start Date 11/29/2010	Consumer Name MEMBER99, TEST	Provider Name ILLINOIS TRAINING,	Vendor ID D161742	<input type="button" value="Save Request as Draft"/>
Type of Request INITIAL	Consumer ID ILLTEST99	Provider ID 676767	NPI # for Authorization SELECT...	
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Therapy/Counseling	Type of Care	Authorized User

Date Therapy/ Counseling, Community Support Group or Psychosocial Rehabilitation Started:

Clinical Staff to Contact if questions:

Phone #: Ext:

Fax #:

Encrypted Email address:

Diagnosis

Please re-register the consumer if any of the displayed diagnosis information has changed since the last time you registered the consumer. Please indicate primary diagnosis.

Axis I	Axis II
*Diagnosis Code 1 <input type="text" value="295.1"/> Description SCHIZOPHRENIC DISORDERS DISORGAN	*Diagnosis Code 1 <input type="text" value="301.7"/> Description ANTISOCIAL PERSONALITY DISORDER
Diagnosis Code 2 <input type="text" value="300.21"/> Description PANIC DISORDER WITH AGORAPHOBIA	Diagnosis Code 2 <input type="text" value="301.8"/> Description OTHER PERSONALITY DISORDERS
Diagnosis Code 3 <input type="text" value="304.30"/> Description CANNABIS DEPENDENCE	Diagnosis Code 3 <input type="text" value="799.9"/> Description DIAGNOSIS DEFERRED (AXIS 1 OR 2)

Axis III	Axis IV
*Diagnosis Code 1 <input type="text" value="ALLERGIES"/>	<p style="font-size: x-small; margin-top: 5px;">Check all that apply</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> None <input type="checkbox"/> Educational problems <input checked="" type="checkbox"/> Financial problems <input checked="" type="checkbox"/> Housing problems <input type="checkbox"/> Occupational problems <input type="checkbox"/> Other psychosocial and environmental problems </div> <div style="width: 45%;"> <input type="checkbox"/> Problems with access to health care services <input type="checkbox"/> Problems related to interaction w/legal system/crime <input checked="" type="checkbox"/> Problems with Primary support group <input checked="" type="checkbox"/> Problems related to the social environment <input type="checkbox"/> Unknown </div> </div>
Diagnosis Code 2 <input type="text" value="OBESITY"/>	

Axis V

Current GAF Score <input type="text" value="38"/>	Highest GAF Score in the Past Year <input type="text" value="58"/>
Current CGAS Score <input type="text"/>	Highest CGAS Score in the Past Year <input type="text"/>

Psychotropic Medications

1. Medication <input type="text"/> Description <input type="text"/> Dosage <input type="text"/> Frequency <input type="text"/> SELECT... Is medication found to be effective? <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A	Side effects? <input type="radio"/> Yes <input type="radio"/> No	Usually adherent? <input type="radio"/> Yes <input type="radio"/> No	Prescriber <input type="text"/> SELECT...
2. Medication <input type="text"/> Description <input type="text"/> Dosage <input type="text"/> Frequency <input type="text"/> SELECT... Is medication found to be effective? <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A	Side effects? <input type="radio"/> Yes <input type="radio"/> No	Usually adherent? <input type="radio"/> Yes <input type="radio"/> No	Prescriber <input type="text"/> SELECT...
3. Medication <input type="text"/> Description <input type="text"/> Dosage <input type="text"/> Frequency <input type="text"/> SELECT... Is medication found to be effective? <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A	Side effects? <input type="radio"/> Yes <input type="radio"/> No	Usually adherent? <input type="radio"/> Yes <input type="radio"/> No	Prescriber <input type="text"/> SELECT...
4. Medication <input type="text"/> Description <input type="text"/> Dosage <input type="text"/> Frequency <input type="text"/> SELECT... Is medication found to be effective? <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> N/A	Side effects? <input type="radio"/> Yes <input type="radio"/> No	Usually adherent? <input type="radio"/> Yes <input type="radio"/> No	Prescriber <input type="text"/> SELECT...

Back Next

© 2010 ValueOptions® ProviderConnect v3.17.00

31. Provider will complete all required fields.

32. Click the %Next+tab

33. Provider will be taken to the %LOCUS Results+Screen. ***If the consumer is 18 or older, this information is required.

Requested Services Header

Requested Start Date 11/29/2010	Consumer Name MEMBER99, TEST	Provider Name ILLINOIS TRAINING,	Vendor ID D161742	<input type="button" value="Save Request as Draft"/>
Type of Request INITIAL	Consumer ID ILLTEST99	Provider ID 676767	NPI # for Authorization SELECT... <input type="text"/>	
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Therapy/Counseling	Type of Care	Authorized User <input type="text"/>

LOCUS Results

Please re-register the consumer if any of the displayed LOCUS information has changed since the last time you registered the consumer.

Functional Impairment Domain Scores	Note: Locus Results information should be populated for Adult Consumers.	
Risk of Harm	<input type="text" value="2"/>	Recovery Environment - Environmental Stressors <input type="text" value="2"/>
Functional Status	<input type="text" value="4"/>	Recovery Environment - Environmental Support <input type="text" value="1"/>
Co-morbidity	<input type="text" value="2"/>	Recovery And Treatment History <input type="text" value="4"/>
Composite Score	<input type="text" value="16"/>	Acceptance and Engagement <input type="text" value="1"/>

LOCUS Recommended Level of Care SELECT...
 Assessor Recommended Level of Care SELECT...
 Reason for Deviation

 (of 200)

34. Complete %Functional Impairment Domain Scores+

35. Select %LOCUS Recommended Level of Care+
36. Select %Assessor Recommended Level of Care+
37. Provide narrative explanation of any %Reason for Deviation+in appropriate text box
38. If the consumer is less than 18 years old, the Ohio Scale or Devereaux Scale Results must be completed.
 - a. For youth ages 5-17, the Ohio Scale is required
 - b. For children under the age of 5 and under, the DECA Subscale is required

Ohio Scale Results

Worker Ohio Problem Severity Scale Score (For youth age 5 - 17) (0-100)

Admission (all) Current (if in treatment more than 90 days)

Devereaux Scale Results

DECA Subscale (For children under the age of 3)

Protective Factor Scores

Admission (all) % Current (if in treatment more than 90 days) %

DECA Subscale (For children over the age of 3, under the age of 5)

Protective Factor Scores

Admission (all) % Current (if in treatment more than 90 days) %

Behavioral Concerns

Admission (all) % Current (if in treatment more than 90 days) %

39. At the bottom of the page, indicate whether the required documents will be attached, faxed, or not applicable for each item.

Required Documents

All required supporting documents for this request, including the Mental Health Assessment and Individual Treatment Plan, must either be attached as "secure clinical" documents to this application or faxed to the Collaborative (at 866-928-7177) within one business day of this request submission. Should the required documents not be faxed to the Collaborative within one business day, the request will not be considered for processing. The provider will be required to submit a new request for authorization.

Attached	Faxed	N/A	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health Assessment dated within the past year.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Individual Treatment Plan dated within past six months.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Health Assessment Update, if indicated.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other clinical documentation supporting medical necessity.

Back Next

40. Click the %Next+tab
41. Provider will be taken to the %Services Requested+screen

Requested Services Header

Requested Start Date 11/29/2010	Consumer Name MEMBER99, TEST	Provider Name ILLINOIS TRAINING,	Vendor ID D161742	<input type="button" value="Save Request as Draft"/>
Type of Request INITIAL	Consumer ID ILLTEST99	Provider ID 676767	NPI # for Authorization SELECT...	Authorized User <input type="text"/>
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Therapy/Counseling	Type of Care	

Services Requested

<input checked="" type="checkbox"/> Therapy/Counseling - Individual	Start Date 12012010	End Date 02162011	Number of Units 20
<input type="checkbox"/> Therapy/Counseling - Group	Start Date	End Date	Number of Units
<input checked="" type="checkbox"/> Therapy/Counseling - Family	Start Date 12012010	End Date 01122011	Number of Units 10

Transition or Discharge Plan

* Is there a written plan to facilitate the consumer's transition to alternative services or to terminate service provision altogether? Yes No

* Has the consumer/guardian been involved in the discharge/transition planning? Yes No

* If the consumer/guardian will not need continuing services, have natural community supports been identified and has the consumer been assisted in accessing them? Yes No N/A

If yes, please provide the following information:

Provider Name	Appointment Date	Services Planned
<input type="text"/>	<input type="text"/>	<input type="text"/>
Provider Name	Appointment Date	Services Planned
<input type="text"/>	<input type="text"/>	<input type="text"/>

* How many days until anticipated discharge or transition to alternative services?

* If the consumer will not need continuing services, have natural community supports been identified and has the consumer been assisted in accessing them? Yes No N/A

* Does the individual have a current Crisis Plan and understand how to access the services and supports included in it? Yes No N/A

* Barriers to Discharge
Check all that apply:

- Consumer is not meeting criteria for lower level of care or discharge
- Transitional services not identified or not available
- Community resources not identified or difficult to obtain
- Consumer/guardian/family not engaged/participating in care or transition planning

* Describe plan to overcome barriers to discharge:
Please provide updates for ongoing requests, as needed.

▼ Narrative History

▼ Narrative Entry (24 of 250)
test test test test test

42. Check appropriate box for type(s) therapy requested (Individual, Group, Family)
43. Indicate %Start Date+, %End Date+, and %Number of Units+requested for each service
44. Complete %Transition or Discharge Plan Section+, providing required narrative
45. Click the %Submit+tab
46. Provider will be taken to the %Determination Status+Screen

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 consumer's authorization history.

Consumer Name ILLTEST MEMBER01	Consumer ID ILLTEST01	Consumer DOB 01/01/1980	Subscriber Name ILLTEST MEMBER01	Subscriber ID ILLTEST01
Pended Authorization # 091810-2-5	Client Authorization # N/A	Type of Request CONCURRENT		
Date of Admission/ Start of Services 11/01/2010	Requested From 11/01/2010	Submission Date 11/16/2010		
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service MENTAL HEALTH	Level of Care THERAPY/COUNSELING	Type of Care	
Reason Code P76				

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

47. Provider can choose to:

- a. Print the Authorization Result
- b. Print the Authorization Request
- c. Download the Authorization Request
- d. Return to Provider Home

Helpful Contact Information

Collaborative Clinical Care Managers 866-359-7953

EDI Helpdesk 888-247-9311

Claims Customer Service 866-359-7953 (ask specifically for Claims Customer Service)

