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

<u>Agenda</u>

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

- <u>Authorization request via ProviderConnect</u> All required and applicable fields completed. The Collaborative will not review requests for authorization submitted via facsimile.
- <u>Current MHA and ITP</u> Securely attached with ProviderConnect request or faxed to the Collaborative (866-928-7177) within 1 business day
- <u>Additional documentation</u> 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 consumeron 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 ‰or Providers+tab



- 3. Click the ‰og In+tab
- 4. Enter User ID

5. Enter Password

6. Click the *bog* In tab+

Please	Log	In
	- 0	

1	Required fields are denoted by an asterisk (*) adjacent to the label.
	Please log in by entering your User ID and password below.
	*User ID
	II you do not remember your User ID, please contact our e-support neip Line.
	Forgot Your Password2
	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.

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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
I Agree I Disagree
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

 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 %pecific Member Search+from the options on the left hand side of the page.

*(PRStaging
Ho	me
Sp	ecific Member Search
Re	gister Member
Au	thorization Listing
En Re	ter an Authorization quest
Vie	ew Clinical Drafts
Cla Su	aim Listing and bmission
En	ter a Special Program plication
ED	I Homepage
En	ter Member Reminders
On	Track Outcomes
Re	ports
My	Online Profile
My	Practice Information
Pro	ovider Data Sheet
Pe	rformance Report

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

Staging				ValueOptions Home	Provider Home	Contact Us	Log Out
Home							
Specific Member Search							
Register Member	Eligibility & Bo	enefits Searc	h				
Authorization Listing							
Enter an Authorization Request	Required fields are der	noted by an asterisk	: (\star) adjacent to	the label.			
View Clinical Drafts	Verify a patient's elig	ibility and benefits ir	formation by ente	ering search criteria belo	w.		
Claim Listing and Submission	*Member ID						
Enter a Special Program Application	Last Name		(No spaces	or dashes)			
EDI Homepage	First Name						
Enter Member Reminders	*Date of Birth		(MMDDYYYY)				
On Track Outcomes	As of Date	11162010	(MMDDYYYY)				
Reports			(
My Online Profile		Search					
My Practice Information							
Provider Data Sheet							
Performance Report							
Compliance							

13. Provider will be taken to the @emographics+screen for the consumer14. Click the @inter an Authorization Request+tab at the left hand side of the screen

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PrStagi	ngnnect						
Home		Demographics	Enrollment History	COB	Benefits	Additional Information	
Specific Consumer	Search						
Register Consume	r						
Authorization Listi	ng	Consumer elig	ibility does not guarante	e payment	. Eligibility is as	s of today's date and is provi	ded by our clients.
Enter an Authoriza Request	tion						
View Clinical Draft	S	Consumer?					Eligibility
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Submission		Alternate ID					Expiration Date
Enter a Special Pro	gram	Consumer Na	me	MEMBERO	1, ILLTEST		COB Effective Date?
EDI Homonogo		Date of Birth		01/01/19	80		View Funding Source Enrollmen
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On Track Outcome	5	Alternate Add	ress	chicado,	12 00000		Subscriber ID
Reports		Marital Status		_			Subscriber Name
My Unline Profile							Subsciber Name

15. Provider will be taken to the %Disclaimer+



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

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

Provid	ler			
Provider II	D S TRAINING - 676767 💌	Provider Last Name ILLINOIS TRAINING	Provider First N	łame
Select	Service Address			
Canture	Provider Provider ID	l ast Name	Vendor Vendor ID	Vendor Last Name
cupture		Eirst Nama		Vandor Eirst Namo
	Tax ID	Service Address	Paid To Vendor ID	Pay To Address
	Alternate ID			
0	676767	ILLINOIS TRAINING	D161742	ILLINOIS TRAINING
	361234567	123 TRAINING AVE		123 TRAINING AVE
		CHICAGO, IL 60290-		CHICAGO, IL 60290-

- 18. Select service address
- 19. Click the %Jext+tab
- 20. Provider will be taken to the Requested Services Header+

	es Header			
All fields marked with an aste Note: Disable pop-up blocker	risk (*) are required. functionality to view all appropriate links.			
*Requested Start Date (MMI	DDYYYY)	*Level of Service		
11292010		OUTPATIENT		
*Type of Service	"Level of Care			
MENTAL HEALTH	COMMUNITY SUPPORT GROUP			
Provider				
Tax ID	Provider ID	Provider Last Name	Vendor ID	
361234567	676767	ILLINOIS TRAINING	D161742	
Consumer				
Consumer ID ILLTEST99	Last Name MEMBER99	First Name TEST	Date of Birth (MMDDYYYY) 01011980	
Attach a Docume	nt			
Attach a Docume	nt			
Attach a Docume	nt attach a document with this Request renuixed if you are unhading a document			
Attach a Docume Complete the form below to The following fields are only i	nt attach a document with this Request required if you are uploading a document			
Attach a Docume	nt attach a document with this Request required if you are uploading a document Does this Document contain clinical infor	nation about the Consumer? Yes 🔿 No C)	
Attach a Docume Complete the form below to The following fields are only i "Document Type: "Document Description	nt attach a document with this Request required if you are uploading a document Does this Document contain clinical infor SELECT	ration about the Consumer? Yes O No C)	
Attach a Docume Complete the form below to The following fields are only i "Document Type: "Document Description	nt attach a document with this Request required if you are uploading a document Does this Document contain clinical infon SELECT UploadFile Click to attach a documer	ration about the Consumer? Yes O No C) k to delete an attached document	

- 21. Enter a Requested Start Date+for the start date of the authorization
- 22. Enter % evel of Service+= % utpatient+
- 23. Enter ‰ype of Service+= ‰ental Health+
- 24. Enter % evel of Care+= Community Support Group+

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

PRStaging						ProviderConnect Home
DIAGNOSIS ASSESSMENTS ASSESSMENTS DISCHARGE P	OR 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	٦	
Type of Request	Consumer ID ILLTEST99	Provider ID 676767		NPI # for Authorization	_	
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 di	isplayed diagnosis information	n has changed since the last time you regis	tered the consumer.			
Arrie I			Arrie II			
			AXIS II			
*Diagnosis Code 1 Description			*Diagnosis Code 1	Description		
Diagnosis Code 2 Description			Diagnosis Code 2	Description		
Diagnosis Code 3 Description			Diagnosis Code 3	Description		
Axis III			Axis IV			
*Diagnosis Code 1 SELECT	~		Check all that apply			
			None		Problems with access	to health care services
			Educational pr	oblems	Problems related to int	teraction w/legal system/crime
			Financial proble	ems	Problems with Primary	support group
				ens	Uoknown	e social environment
			Other psychos	social and environmental problems		
Diagnosis Code 2						
SELECT	*					
Axis V						
Current GAF Score			Highest GAF Score	in the Past Year		
Current CGAS Score			Highest CGAS Scor	e in the Past Year		

Psychotropic Medications			
1. Medication Description Dosage Frequency SELECT	Side effects?	Usually adherent?	Prescriber
Is medication found to be effective?			
2. Medication Description Dosage Frequency SELECT	Side effects?	Usually adherent?	Prescriber SELECT
Is medication found to be effective?			
3. Medication Description Dosage Frequency SELECT	Side effects?	Usually adherent?	Prescriber SELECT
Is medication found to be effective?			
4. Medication Description Dosage Frequency SELECT	Side effects?	Usually adherent?	Prescriber SELECT
Is medication found to be effective?			
Back Next			
© 2010 ValueOptions [®] ProviderConnect v3.17.00			

- 31. Provider will complete all required fields.
- 32. Click the %Jext+tab
- 33. Provider will be taken to the **&OCUS** Results+Screen. ***If the consumer is 18 or older, this information is required.

Requested Start Date 12/01/2010	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			
Level of Service DUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Community Support Group	Type of Care	Authorized User			
LOCUS Results							
Please re-register the consumer if any of t	he displayed LOCUS inf	ormation has changed since the	last time you regist	ered the consumer.			
Functional Impairment Domain Score	s Note:	Locus Results information	should be populate	ed for Adult Consumers.			
Risk of Harm	2	~	Recovery Environme	ent - Environmental Stressors	2		~
Functional Status	2	~	Recovery Environme	ent - Environmental Support	3		~
Co marbidity	2		Pasavany And Trast	mont History	5		
Connorblaicy	1	*	Recovery And Treat	anene history	2		~
			Acceptance and Eng	jagement	3		~
Composite Score	15						
LOCUS Recommended Level of Care				Reason for Deviation			
II-LOW INTENSITY COMMUNITY BAS	SED SERVICES (14-1	.6) 👻		Namative History			
				Narrative History			1
						~	
		6) ×			((200)	,	
II-LOW INTENSITY COMMONITY DA.	SED SERVICES (14-1	.0)		- Narrative Entry	(of 200)		
						<u>~</u>	

- 34. Complete % Sunctional Impairment Domain Scores+
- 35. Select ‰OCUS Recommended Level of Care+
- 36. Select & ssessor 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	n Severity Scale Score ((For youth age 5 - 17) (0-100)		
Admission (all)		Current (if in treatment more than 90 days)		
Devereaux	Scale Resu	llts		
DECA Subscale (For c	hidren under the age o	of 3)		
Pro	tective Factor Scores			
Admission (all)	%	Current (if in treatment more than 90 days)	9%	
DECA Subscale (For c	hidren over the age of	3, under the age of 5)		
Prote	ective Factor Scores			
Admission (all)	%	Current (if in treatment more than 90 days)	96	
E	Behavioral Concerns			
Admission (all)	- Ar	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.

Requi	ired D	ocu	ments
All required attached a this reques considered	supporting s "secure of t submissio for proces	docume inical' de n. Shoul sing, The	ents for this request, including the Mental Health Assessment and Individual Treatment Plan, must ether be ocuments to this application or faxed to the Colaborative (at 866-928-7177) within one business day of d the required documents not be faxed to the Colaborative within one business day, the request will not be e provider will be required to submit a new request for authorization.
Attached	Faxed	N/A	
0	0		Mental Health Assessment dated within the past year.
0	0		Individual Treatment Plan dated within past six months.
0	0	0	Mental Health Assessment Update, if indicated.
0	0	0	Other clinical documentation supporting medical necessity.
Back	Nex	t	

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

PRStaging					ProviderConnect Home
DIAGNOSIS	ION OR RESULTS				
PAGE 3 of 4					
Requested Services Header	r				
Requested Start Date 11/29/2010	Consumer Name MEMBER99, TEST	Provider Name ILLINOIS TRAINING,	Vendor ID D161742	Save Request as Draft	
Type of Request NITIAL	Consumer ID ILLTEST99	Provider ID 676767		NPI # for Authorization	
Level of Service DUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Community Support Group	Type of Care	Authorized User	
Services Requested					
Community Support Group	Start Date 11292010	End Date 1222201	0 🔯	Number of Units	
Transition or Discharg * Is there a written plan to facilitate the co service provision altogether?	e Plan	ive services or to terminate			Yes ○ No
* Has the consumer/guardian been involved	l in the discharge/transition pl	anning?			⊙ Yes ◯ No
* If the consumer will transition to alternati	ve services, have treatment n	esources been identified and			Yes ○ No ○ N/A
est test test test Back Submit	 ▲ ▲ 				
2010 ValueOptions [®] ProviderConnect v3.17	.00				
Consumer/guardian/family r	not engaged/participatir	ng in care or transition plannin	g		
* Describe plan to overcome barriers Please provide updates for ongoing :	s to discharge: <i>requests, as needed.</i>				
- Narrative History					
V1WSSO 091810, 11:59:55 ET test test test test test test test test					
✓ Narrative Entry (35 of 250)					
test test test test test test	~				
Back Submit					
2010 ValueOptions [®] ProviderConnect	t v3.17.00				

- 42. Indicate % Start Date+, % Ind Date+, and % Jumber of Units+requested
- 43. Complete % ansition or Discharge Plan Section+, providing required narrative.
- 44. Click the Submit+tab
- 45. Provider will be taken to the @etermination Status+Screen

e services requested requir	e additional review. You v	vill be contacted regardin	a the status of this requ	est if further
formation is needed. An aut	horization decision will be	e made within the require	d timeframes and detail	s of that decis
ay be found under the consi	imer's authorization histo	ory.		
nsumer Name	Consumer ID	Consumer DOB	Subscriber Name	Subscriber ID
LTEST MEMBER01	ILLTEST01	01/01/1980	ILLTEST MEMBER01	ILLTEST01
nded Authorization #	Client Authorization #	Type of Request		
1810-3-40	N/A	CONCURRENT		
te of Admission/ Start of Services	Requested From	Submission Date		
/08/2010	11/08/2010	11/17/2010		
vel of Service	Type of Service	Level of Care	Type of Care	
ITPATIENT/COMMUNITY BASED	MENTAL HEALTH	COMMUNITY SUPPORT		
Attached Documents	There are no documents attache	d with this Authorization Request		
Attached Documents	There are no documents attache	d with this Authorization Request		
Document Title	Document Description			
Authorization Printing & Downl	loading Options: ndscape' format)			
Print Authorization Result	Print Authorization Request	Download Authorization R	equest Return to	Provider Home
Print Authorization Result Print the Results page (this page)	Print Authorization Request Print the entire Authorization Requ	Download Authorization R Download the entire Authorizat	equest Return to	Provider Home iderConnect homepag
Print Authorization Result Print the Results page (this page)	Print Authorization Request Print the entire Authorization Requ	Download Authorization R Download the entire Authorization	equest Return to the Prov.	Provider Home iderConnect homepag
Print Authorization Result Print the Results page (this page)	Print Authorization Request Print the entire Authorization Requ	Download Authorization R Download the entire Authorizat	equest Return to	Provider Home iderConnect homepag
Print Authorization Result Print the Results page (this page)	Print Authorization Request Print the entire Authorization Requ	Download Authorization R est Download the entire Authorizat	equest Return to the Prov.	Provider Home

- 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:





2. Once at the homepage, click the ‰or Providers+tab



- 3. Click the **‰**og In+tab
- 4. Enter User ID

5. Enter Password

6. Click the % og In tab+

Please	Log I	n
r rettoe .		

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.
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.

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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							
I Agree I Disagree							
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							

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*(PRStaging
Но	me
Sp	ecific Member Search
Re	gister Member
Au	thorization Listing
En Re	ter an Authorization quest
Vie	ew Clinical Drafts
Cla Su	aim Listing and bmission
En Ap	ter a Special Program plication
ED	I Homepage
En	ter Member Reminders
On	Track Outcomes
Re	ports
My	Online Profile
My	Practice Information
Pro	ovider Data Sheet
Pe	rformance Report

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

Staging				ValueOptions Home	Provider Home	Contact Us	Log Out		
Home									
Specific Member Search									
Register Member	Eligibility & Be	enefits Searc	h						
Authorization Listing									
Enter an Authorization Request	Required fields are denoted by an asterisk (st) adjacent to the label.								
View Clinical Drafts	Verify a patient's eligi	Verify a patient's eligibility and benefits information by entering search criteria below.							
Claim Listing and Submission	*Member ID								
Enter a Special Program Application	Last Name		(No spaces	or dashes)					
EDI Homepage	First Name								
Enter Member Reminders	*Date of Birth		(MMDDYYYY)						
On Track Outcomes	As of Date	11162010	(MMDDYYYY)						
Reports			(
My Online Profile		Search							
My Practice Information									
Provider Data Sheet									
Performance Report									
Compliance									

13. Provider will be taken to the @emographics+screen for the consumer14. Click the @inter an Authorization Request+tab at the left hand side of the screen

🗄 💌 🏉 (O) Work Queue	🏉 (O) Home	6 ProviderCo	nnect - Pr ×				🛐 * 🔊 - 🖃 👼 * Page * Safety * Too	
PrStagi	ngNNECT							
Home		Demographics	Enrollment History	COB	Benefits	Additional Information		
Specific Consumer	Search							
Register Consume	r							
Authorization Listi	ng	Consumer elig	Consumer eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.					
Enter an Authoriza Request	ition							
View Clinical Draft	S	Consumer?]				Eligibility	
Claim Listing and		Consumer ID		ILLTEST01			Effective Date	
Submission		Alternate ID					Expiration Date	
Enter a Special Pro	ogram	Consumer Na	MEMBER01, ILLTEST			COB Effective Date?		
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Enter Member Per	EDI Homepage		1	1 TEST DRIVE				
On Track Outcomes			A	PT 2D HICAGO	TI 60608		Subscriber	
Poports	5	Alternate Add	ress				Subscriber ID	
My Online Profile		Marital Status					Subscriber Name	
My Online Profile		Home Phone	Home Phone					

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

PRStaging	ProviderConnect H
Disclaimer	
Please note that ValueOptions recognizes only fully completed and submitted requests as formal completion will not result in a completed request. ValueOptions does not recognize or retain data Authorization Request " process, you will receive a screen noting the pended or approved status been received by ValueOptions.	requests for authorization. Exiting or aborting the process prior to for partially completed requests. Upon full completion of the " Enter an of your request. Receipt of this screen is notification that your request ha
Next	

- 16. If provider wishes to proceed with authorization request, they will click the %Jext+ tab
- 17. Provider will be taken to the % Rrovider+

screen

Y PR	Stagingweet				ProviderConnect Home	
Provid	er					
Provider ID ILLINOIS	5 TRAINING - 676767 💌	rovider Last Name LLINOIS TRAINING	Provider First. Name			
Select	Service Address Provider		Vendor			
Capture	Provider ID	Last Name	Vendor ID	Vendor Last Name		
		First Name		Vendor First Name	Vendor First Name	
	Tax ID	Service Address	Paid To Vendor ID	Pay To Address		
	Alternate ID					
۲	676767	ILLINOIS TRAINING	D161742	ILLINOIS TRAINING		
	361234567	123 TRAINING AVE		123 TRAINING AVE		
		CHICAGO, IL 60290-		CHICAGO, IL 60290-		
Back	Next					

- 18. Select service address
- 19. Click the %Jext+tab
- 20. Provider will be taken to the Requested Services Header+page

Requested Services Header Al fields marked with an asterisk (*) are required, Note: Deable por-up blocker functionality to view al appropriate links. Forevenued one Dear (Windowski)								
All fields marked with an astensk (*) are required. Note: Disable pop-up blocker functionality to view all appropriate links.								
12012010 Image: Control of the service								
*Type of Service *Level of Care MENTAL HEALTH PSYCHOSOCIAL REHABILITATION								
» 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 O No O								
*Document Description SELECT								
UploadFile Clok to attach a document Delete Clok to delete an attached document Attached Document:								

- 21. Enter a Requested Start Date+for the start date of the authorization
- 22. Enter % evel of Service+= % Outpatient+
- 23. Enter ‰ype of Service+= ‰ental Health+
- 24. Enter ‰evel of Care+= ‰sychosocial Rehabilitation+
- 25. If provider wishes to attach all required supporting documentation (MHA, ITP, additional documents supporting medical necessity), click the %/es+button to the right of %/ocument Type+
- 26. Select appropriate document from list in drop down menu in @ocument Description+
- 27. Click the %Jpload+tab
- 28. Upload each document following steps 25, 26, and 27
- 29. Click %Jext+
- 30. Provider will be taken to the Requested Services Header+screenq

equested Start Date 2/01/2010		Descrides News	Mar 1 - 10				
	MEMBER99, TEST	Provider Name ILLINOIS TRAINING,	Vendor ID D161742	Save Reques	t as Draft		
ype of Request DNCURRENT	Consumer ID ILLTEST99	Provider ID 676767		NPI # for Authoriza	ition		
evel of Service UTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Psychosocial Rehabilitation	Type of Care	Authorized User			
ate Therapy/ Counseling, Community Supp roup or Psychosocial Rehabilitation Started:	port	112920	10 🔝				
linical Staff to Contact if questions est test test		Phone # 999 99	99 9999 Ext]		Fax #	9999
ncrypted Email address							
Diagnosis							
lease re-register the consumer if any of the	e displayed diagnosis informatio	ion has changed since the last time	you registered the consumer	n			
lease indicate primary diagnosis.			Avie II				
			AXIS II	Description			
295.04 SCHIZOPHRENIC-	SIMPLE-CHRONIC-ACU		799.9	DIAGNOSIS DEF	ERRED (AXIS 1	OR 2)	
V71.09 NO DIAGNOSIS			Diagnosis Code 2 799.9	Description DIAGNOSIS DEFE	RRED (AXIS 1	OR 2)	
			Financial prol	blems	V	Problems with Primary su	pport group
			☑ Housing prob	blems		Problems related to the s conment	ocial
			Occupational	I problems		Unknown	
			Other psych problems	iosocial and environ	mental		
Diagnosis Code 2							
NONE		· ·					
NONE Axis V		•					
NONE Axis V Current GAF Score 58		•	Highest GAF Scor	e in the Past Year	60		
NONE Axis V Current GAF Score 58 Psychotropic Medicat	ions	•	Highest GAF Scor	<u>e in the Past Year</u>	60		
NONE Axis V Current GAF Score 58 Psychotropic Medicat	ions	•	Highest GAF Scor	re in the Past Year	60		
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- 31. Provider will complete all required fields.
- 32. Click the %Jext+tab
- 33. Provider will be taken to the **%**OCUS Results+Screen.

Requested Start Date 12/01/2010	Consumer Name MEMBER99, TEST	Provider Name ILLINOIS TRAINING,	Vendor ID D161742	Save Request as Draft]	
Type of Request CONCURRENT	Consumer ID ILLTEST99	Provider ID 676767		NPI # for Authorization		
Level of Service DUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Psychosocial Rehabilitation	Type of Care	Authorized User		
LOCUS Results						
Please re-register the consumer if any of t	he displayed LOCUS information	n has changed since the last time you re	gistered the consumer.			
Functional Impairment Domain Scores	Note: Locu	s Results information should be pop	oulated for Adult Cor	nsumers.		
Risk of Harm	2	v	Recovery Environ	ment - Environmental Stressors	1	~
Functional Status	3	×	Recovery Environ	nment - Environmental Support	2	~
Co-morbidity	3	~	Recovery And Tr	reatment History	4	~
			Acceptance and	Engagement	1	~
Composite Score	16					
LOCUS Recommended Level of Care				Reason	for Deviation	
II-LOW INTENSITY COMMUNITY BAS	ED SERVICES (14-16)	v				
				Nan	ative History	
Assessor Recommended Level of Care						~
II-LOW INTENSITY COMMUNITY BAS	ED SERVICES (14-16)	~				~

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

LOCUS Rec II-LOW I	ommendeo NTENSITY	COMM	f Care UNITY BASED SERVICES (14-16)	Reason for Deviation Narrative History	~
Assessor R	ecommend	ed Level	of Care		
II-LOW I	NTENSITY	СОММ	UNITY BASED SERVICES (14-16)		· · ·
				Narrative Entry (of 200)	
Requi	red D	ocu	ments		
All required attached as this request considered	supporting s "secure cl submission for process	docume inical" do n. Shouk ing. The	nts for this request, including the Mental Health Assessment and Individual Treatment Pl cuments to this application or faxed to the Collaborative (at 866-928-7177) within one bu the required documents not be faxed to the Collaborative within one business day, the provider will be required to submit a new request for authorization.	an, must either be siness day of request will not be	
Attached	Faxed	N/A			
0	0		Mental Health Assessment dated within the past year.		
0	0		Individual Treatment Plan dated within past six months.		
0	0	0	Mental Health Assessment Update, if indicated.		
0	0	0	Other clinical documentation supporting medical necessity.		
Back	Next				

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

PAGE 3 of 4					
Requested Services Heade	r				
Requested Start Date 2/01/2010	Consumer Name MEMBER99, TEST	Provider Name ILLINOIS TRAINING	Vendor ID 6, D161742	Save Request as Draft	
Type of Request CONCURRENT	Consumer ID ILLTEST99	Provider ID 676767		NPI # for Authorization SELECT	
Level of Service DUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Psychosocial Reha	Type of Care bilitation	Authorized User	
Services Requested					
Psychosocial Rehabilitation	Start Date 12012010	10	End Date 01122011	Number of Units	
		_			
ware itige of Discharge	o Dian				
Is there a written plan to facilitate the c ervice provision altogether?	Je Plan onsumer's transition to alterna	tive services or to termina	ate		Yes No
Has the consumer/guardian been involve	d in the discharge/transition p	lanning?			⊙ Yes ◯ No
If the consumer will transition to alternat	ive services, have treatment r	esources been identified	and		◯ Yes ④ No ◯ N/A
If yes, please provide the following info	mation:				
Provider Name	Appointment	Date Servi	ces Planned		
íí	()			~	
Provider Name	Appointment	Date Servic	tes Planned	<u>^</u>	
					15
The consumer will not need continuing	e or transition to alternative s	ervices? nity sunnorts been identi	fied		Yes O No O N/A
nd has the consumer been assisted in acc	essing them?	inc, supports occurristing			
Does the individual have a current Crisis Pl	an and understand how to ac	cess the services and sup	ports included in it?		Yes O No O N/A
Check all that apply.					
Consumer is not meeting criteria fo	r lower level of care or disch	arge			
Transitional services not identified of	ir not available				
Consumer/guardian/family not enga	ided/participating in care or t	ransition planning			
" Describe plan to overcome barriers to dis	charge:				
Please provide updates for ongoing reques	ts, as needed.				
Narrative History					
ast test test test test test	~				
Narrative Entry (24 of 250)					
Narrative Entry (24 of 250) est test test test	^				
Narrative Entry (24 of 250) est test test test	×				
• Narrative Entry (24 of 250) est test test test	×				

- 41. Indicate % Start Date+, % Ind Date+, and % Jumber of Units+requested
- 42. Complete % ransition or Discharge Plan Section+, providing required narrative.
- 43. Click the Submit+tab
- 44. Provider will be taken to the @etermination Status+Screen

C C C C C C C C C C C C C C C C C C C			P	roviderConnect Home
Determination Status:	*******	**************************************	• ********	**
The services requested require a nformation is needed. An autho nay be found under the consum	additional review. Norization decision w ner's authorization	You will be contacted re vill be made within the r history.	garding the status of this requ equired timeframes and detail	est if further s of that decision
Consumer Name	Consumer ID	Consumer DOB	Subscriber Name	Subscriber ID
LLTEST MEMBER01	ILLTEST01	01/01/1980	ILLTEST MEMBEROI	ILLTEST01
Pended Authorization #	Client Authorization #	Type of Request		
91810-4-14	N/A	CONCURRENT		
Date of Admission/ Start of Services	Requested From	Submission Date		
11/01/2010	11/01/2010	11/17/2010		
evel of Service	Type of Service	Level of Care	Type of Care	
OUTPATIENT/COMMUNITY BASED	MENTAL HE	ALTH PSYCHOSOCIA	L REHABILITATION	
Reason Code				
Reason Code P76				
Reason Code P76 Provider Name & Address	Provider ID		NDT	# for Authorization
Reason Code P76 Provider Name & Address	Provider ID		NPI	# for Authorization
Reason Code P76 Provider Name & Address ILLINOIS TRAINING	Provider ID 676767		NPI N/A	# for Authorization
Reason Code P76 Provider Name & Address ILLINOIS TRAINING 123 TRAINING AVE CUICAGO IL 60390	Provider ID 676767		NPI N/ <i>P</i>	# for Authorization
Reason Code P76 Provider Name & Address ILLINOIS TRAINING 123 TRAINING AVE CHICAGO IL 60290	Provider ID 676767		NPI N/ <i>P</i>	# for Authorization
Reason Code P76 Provider Name & Address ILLINOIS TRAINING 123 TRAINING AVE CHICAGO IL 60290 Message	Provider ID 676767		NPI N/ <i>P</i>	# for Authorization
Reason Code P76 Provider Name & Address ILLINOIS TRAINING 123 TRAINING AVE CHICAGO IL 60290 Message P76	Provider ID 676767		NPI N/A	# for Authorization
Reason Code P76 Provider Name & Address ILLINOIS TRAINING 123 TRAINING AVE CHICAGO IL 60290 Message P76 Attached Documents	Provider ID 676767	ients attached with this Autho	NPI N/A	# for Authorization

- 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 % or Providers+tab



- 3. Click the ‰og In+tab
- 4. Enter User ID

- 5. Enter Password
- 6. Click the *bog* 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 Eorgot 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
I Agree I Disagree
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

 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 ‰pecific Member Search+from the options on the left hand side of the page.

* (1	Staging
Hom	e
Spec	ific Member Search
Regi	ster Member
Auth	orization Listing
Ente Requ	r an Authorization Jest
View	/ Clinical Drafts
Clair Subr	n Listing and nission
Ente Appl	r a Special Program Ication
EDI	Homepage
Ente	r Member Reminders
On T	rack Outcomes
Repo	orts
My C	Inline Profile
My P	ractice Information
Prov	ider Data Sheet
Perf	ormance Report
Com	pliance

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

Staging						Log Out
Home						
Specific Member Search						
Register Member	Eligibility & Bo	enefits Searc	h			
Authorization Listing						
Enter an Authorization Request	Required fields are den	ioted by an asterisk	: (\star) adjacent to	the label.		
View Clinical Drafts	Verify a patient's eligi	ibility and benefits in	formation by ente	ering search criteria belo	w.	
Claim Listing and Submission	*Momber ID					
Enter a Special Program Application	Last Name		(No spaces	or dashes)		
EDI Homepage	First Name					
Enter Member Reminders	*Date of Birth					
On Track Outcomes	As of Date	11162010	(ММОРУУУУ)			
Reports			(111001111)			
My Online Profile		Search				
My Practice Information		Search				
Provider Data Sheet						
Performance Report						
Compliance						

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

🛉 Favorites 🛛 👍 🏉 Suggested Sites 👻 🛛	M Free Hotmail	🙋 Web Slice Gallery 🝷					
😤 🔹 🌈 (O) Work Queue 🫛 🌈 (C) Home	🏉 ProviderCor	nect - Pr X				🛐 🔹 🔝 👘 🖆 Page 👻 Safety 👻 Tools
PrStaging	NECT						
Home		Demographics	Enrollment History	COB	Benefits	Additional Information	
Specific Consumer Search							
Register Consumer							
Authorization Listing		Consumer eligi	bility does not guarantee	payment	Eligibility is as	of today's date and is prov	ided by our clients.
Enter an Authorization Request							
View Clinical Drafts		Consumer?					Eligibility
Claim Listing and		Consumer ID	I	LTESTO			Effective Date
Submission		Alternate ID					Expiration Date
Enter a Special Program		Consumer Nar	me M	EMBERO	I, ILLTEST		COB Effective Date?
EDI Homenage		Date of Birth	0	1/01/19	80		View Funding Source Enrollment De
Enter Member Reminders		Address	1	TEST DR	IVE		
On Track Outcomes			A	PT 2D HICAGO,	IL 60608		Subscriber
Reports		Alternate Addr	ess				Subscriber ID
My Onlino Profilo		Marital Status	-				Subscriber Name
My Drastian Tafamatian		Home Phone					-

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

PRStaging	ProviderConnect
Disclaimer	
Please note that ValueOptions recognizes only fully completed and submitted requests as formal requests f completion will not result in a completed request. ValueOptions does not recognize or retain data for partial Authorization Request " process, you will receive a screen noting the pended or approved status of your re been received by ValueOptions.	or authorization. Exiting or aborting the process prior to ly completed requests. Upon full completion of the " Enter an quest. Receipt of this screen is notification that your request ha
Next	

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

rovid	er				
rovider ID ILLINOIS	5 TRAINING - 676767 💌	Provider Last Name ILLINOIS TRAINING	Provider First Nam	ie	
	Provider		Vendor		
Capture	Provider ID	Last Name	Vendor ID	Vendor Last Name	
		First Name		Vendor First Name	
	Tax ID	Service Address	Paid To Vendor ID	Pay To Address	
	Alternate ID				
۲	676767	ILLINOIS TRAINING	D161742	ILLINOIS TRAINING	
	361234567	123 TRAINING AVE		123 TRAINING AVE	
		CHICAGO, IL 60290-		CHICAGO, IL 60290-	
Back	Next				

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

- 18. Select service address
- 19. Click the %Jext+tab
- 20. Provider will be taken to the %Requested Services Header+

Requested Servic	es Header			
All fields marked with an aste Note: Disable pop-up blocker	risk (*) are required. • functionality to view all appropriate links.			
* <u>Requested Start Date</u> (MMI 11292010	DDYYYY)	*Level of Service OUTPATIENT		
*Type of Service MENTAL HEALTH	*Level of Care THERAPY/COUNSELING			
▶ Provider				
Tax ID 361234567	Provider ID 676767	Provider Last Name ILLINOIS TRAINING	Vendor ID D161742	
Consumer				
Consumer ID ILLTEST99	Last Name MEMBER99	First Name TEST	Date of Birth (MMDDYYYY) 01011980	
Attach a Docume	nt			
Complete the form helow to	attach a document with this Request			
The following fields are only i	required if you are uploading a document			
"Document Type:	Does this Document contain clinical infor	mation about the Consumer? Yes 🔿 No	0	
"Document Description	CELECT			

- 21. Enter a Requested Start Date+for the start date of the authorization
- 22. Enter % evel of Service+= % utpatient+
- 23. Enter ‰ype of Service+= ‰ Health+
- 24. Enter % evel of Care+= % herapy/Counseling+
- 25. If provider wishes to attach all required supporting documentation (MHA, ITP, additional documents supporting medical necessity), click the %kes+button to the right of @ocument Type+
- 26. Select appropriate document from list in drop down menu in @ocument Description+
- 27. Click the %Jpload+tab
- 28. Upload each document following steps 25, 26, and 27
- 29. Click %Jext+

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

* Prstaging					ProviderConnect Home
+DIAGNOSIS ASSESSMENTS TRANSITI	-DIACHOSIS ASSESSMENTS ATRANSTITION OR ARESULTS				
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	
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 Supp Group or Psychosocial Rehabilitation Started:	ort	12012010			
Clinical Staff to Contact if questions test test test		Phone # 999 999	9999 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 consum	er,	
Please indicate primary diagnosis.					
Axis I			Axis II		
Diagnosis Code 1 Description SCHIZOPHRENIC D	ISORDERS DISORGAN		*Diagnosis Code 301.7	1 Description ANTISOCIAL PERSONALIT	Y DISORDER
Diagnosis Code 2 300.21 Description PANIC DISORDER W	ITH AGORAPHOBIA		Diagnosis Code 2 301.8	Description OTHER PERSONALITY DISC	RDERS
Diagnosis Code 3 304.30 Description CANNABIS DEPENDE	INCE		Diagnosis Code 3 799.9	Description DIAGNOSIS DEFERRED (AX	IS 1 OR 2)
Axis III			Axis IV		
"Diagnosis Code 1			Check all that app	ŀ	
ALLERGIES	*		None		Problems with access to health care services
			Educational	problems	Problems related to interaction w/legal system/crime
			Financial pro	blems	Problems with Primary support group
			Housing prot	blems	✓ Problems related to the social environment
			Occupationa	l problems	Unknown
			Other psych	osocial and environmental problem	5
Diagnosis Code 2 OBESITY	~				
Axis V					
Current GAF Score 38			Highest GAF Scor	e in the Past Year 58	
Current CGAS Score			Highest CGAS Sco	ore in the Past Year	

Psychotropic Medications				
1. Medication Description Dosage Frequency SELECT	Side effects?	Usually adherent?	Prescriber SELECT	*
Is medication found to be effective?				
2. Medication Description Frequency SELECT	Side effects?	Usually adherent?	Prescriber SELECT	*
Is medication found to be effective?				
3. Medication Description Dosage Frequency SELECT	Side effects?	Usually adherent?	Prescriber SELECT	~
Is medication found to be effective?				
4. <u>Medication</u> Dosage Frequency SELECT	Side effects?	Usually adherent?	Prescriber SELECT	~
Is medication found to be effective?				
Back Next				
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- 31. Provider will complete all required fields.
- 32. Click the %Jext+tab
- 33. Provider will be taken to the CUS 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	Save Request as Draft		
Type of Request INITIAL	Consumer ID ILLTEST99	Provider ID 676767		NPI # for Authorization		
Level of Service OUTPATIENT/COMMUNITY BASED	Type of Service Mental Health	Level of Care Therapy/Counseling	Type of Care	Authorized User		
LOCUS Results						
Please re-register the consumer if any of the	displayed LOCUS information ha	s changed since the last time you	u registered the consun	ner.		
Functional Impairment Domain Scores	Note: Locus R	esults information should be	populated for Adult	Consumers.		
Risk of Harm	2	¥	Recovery Envir	onment - Environmental Stressors	2	~
Functional Status	4	~	Recovery Envir	onment - Environmental Support	1	~
Co-morbidity	2	~	Recovery And	Treatment History	4	~
			Acceptance ar	nd Engagement	1	~
Composite Score	16					
LOCUS Recommended Level of Care	v			Reas	on for Deviation	
JEECO				Na	arrative History	
					,	~
Assessor Recommended Level of Care	~					*
				► Na	arrative Entry (of 200)	

34. Complete % Sunctional Impairment Domain Scores+

- 35. Select ‰OCUS Recommended Level of Care+
- 36. Select % ssessor 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 Pec	ulte		
Devereaux	Scale Res	uits		
DECA Subscale (For ch	nidren under the age	of 3)		
Prot	ective Factor Scores			
Admission (all)	%	Current (if in treatment more than 90 days)	96	
DECA Subscale (For ch	hidren over the age	of 3, under the age of 5)		
Protec	tive Factor Scores			
Admission (all)	%	Current (if in treatment more than 90 days)	96	
Be	ehavioral Concerns			
	and the second se			

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

Requi	red D	ocu	ments
All required attached as this request considered	supporting s "secure c submissio for process	docume Inical' do n. Shoul sing. The	Ints for this request, including the Mental Health Assessment and Individual Treatment Plan, must ether be cuments to this application or faxed to the Colaborative (at 866-928-7127) within one business day of d the required documents not be faxed to the Colaborative within one business day, the request will not be provider will be required to submit a new request for authorization.
Attached	Faxed	N/A	
0	0		Mental Health Assessment dated within the past year.
0	0		Individual Treatment Plan dated within past six months.
0	0	0	Mental Health Assessment Update, if indicated.
0	0	0	Other clinical documentation supporting medical necessity.
Back	Next	t	

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

PDIAGNOSIS PASSESSMENTS TRANSITIO	PLAN PRESULTS				
PAGE 3 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 Therapy/Counseling	Type of Care	Authorized User	
Services Requested					
V Therapy/Counseling - Individual	Start Date 12012010	End Date 0216201	1	Number of Units	
Therapy/Counseling - Group	Start Date	End Date		Number of Units	
Therapy/Counseling - Family	Start Date 12012010	End Date 0112201	1	Number of Units	
Transition or Discharge	e Plan				
* Is there a written plan to facilitate the con service provision altogether?	nsumer's transition to alternative s	ervices or to terminate			⊙ Yes ◯ No
* Has the consumer/guardian been involved	in the discharge/transition plannin	g?			⊙ Yes ○ No
". If the consumer will transition to alternative	e services, have treatment resour	ces been identified and			○ Yes ○ No ● N/A
If yes, please provide the following inform	nation:				
Provider Name	Appointment Date	Services Planned		<u>^</u>	
				×	
Provider Name	Appointment Date	Services Planned		<u>^</u>	
		-			20
 * How many days until anticipated discharge * If the consumer will not need continuing a 	or transition to alternative service	unnorts haan idantifiad			20 • Yas • No • N/A
a use consumer wai not need contributing services, here natural contributing supports seen inerticied and has the consumer been assisted in accessing them?					
*Does the individual have a current Crisis Plan	n and understand how to access t	the services and supports included	l in it?		⊙ Yes ○ No ○ N/A
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 o	or difficult to obtain	tion planning			
* Describe also to eversome barriers to disch	perior de la care or d'ansi	uon planning			
Please provide updates for ongoing requests	s, as needed.				
-Narrative History					
	<u>^</u>				
(24 of 250)					
Narrative Entry (24 01 250) test test test test	<u>^</u>				
	~				
Back Submit					
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- 42. Check appropriate box for type(s) therapy requested (Individual, Group, Family)
- 43. Indicate Start Date+, Send Date+, and Number of Units+requested for each service
- 44. Complete % ransition or Discharge Plan Section+, providing required narrative
- 45. Click the Submit+tab
- 46. Provider will be taken to the @etermination Status+Screen

The services requested nformation is needed.	require add	litional review. You	will be contacted regarding		
nay be round under en	e consumer	ation decision will b 's authorization hist	e made within the required	d timeframes and detail	lest if further Is of that decision
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		
J91810-2-5		N/A	CONCURRENT		
Date of Admission/ Start of Services	5	Requested From	Submission Date		
11/01/2010		11/01/2010	11/16/2010		
Level of Service		Type of Service	Level of Care	Type of Care	
OUTPATIENT/COMMUNITY E	BASED	MENTAL HEALTH	THERAPY/COUNSELING		
Reason Code					
276					
ched Documents	There are	e no documents attached w	ith this Authorization Request		
ment Title	Documen	t Description			
orization Printing & Dov	vnloading O _I	otions:			
he best print results, please print in	'Landscape' forma	it)			
		int Authorization Desurat	Download Authorization Regu	est Return to Pr	rovider. Home
Print Authorization Result	Pr	Int Authorization Request	Dominioda Addionización ricega		

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)