Connecticut BHP
Supporting Health and Recovery

Online Provider Services Account Request Form

Required fields are marked with an asterisk. * Fax completed form to 855-750-9862 or email to ctbhp@beaconhealthoptions.com

The Account Request Form is only for activating online access to ProviderConnect on the CT BHP website. If you need to update your address, tax ID or NPI information, you will need to contact our Provider Relations Department at 1-877-552-8247. Please do not make additional notations on the Account Request Form unless advised to do so by these instructions or by the CT BHP Provider Relations Department. Please contact the CT BHP Provider Relations Department with any questions.

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Provider, Group Practice or Facility Name** ***If this request is for multiple facilities within the same network, please list the names of all entities user would need access to

_____

***Beacon Provider ID (CBHP#), NPI or Medicaid ID# (005555555)**

_____

Existing User ID ***applicable only to users managing multiple accounts***

_____

***Address**

_____

***City** ***State** ***Zip Code**

_____

***User's Name – Please print clearly**

_____

***User's E-mail address – Please print clearly**

***Telephone Number:** _____ **Fax Number:** _____

Agreement Terms:

A. **The undersigned submitter authorizes Beacon Health Options to receive and process batch registration submissions via the Beacon Health Options Electronic Transport System (ETS) or Beacon Health Options Online Provider Services Program on his/her/its behalf in accordance with the applicable regulations.**

B. **All submitted information must be true, accurate and complete. I/We understand that registrations submitted in falsification or concealment of a material fact may be prosecuted under any applicable state and/or federal laws.**

C. **The Submitter agrees to comply with any laws, rules and regulations governing the Beacon Health Options Online Provider Services/EDI program.**

D. **This is to certify that information submitted via the Beacon Health Options ETS system or Online Provider Services program will be stored in an electronic medium and held by the originator for a period of 90 days or until the submission has been finalized, whichever comes first.**

This is to certify that the following is true:

☐ **I am a provider OR** ☐ **I am office staff of a Provider and am authorized to sign on their behalf.**

Signatures:

_____

Legal name of Organization **Title of individual signing for organization**

_____

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