

Intermediary Authorization Form
Please fax completed form to 866-698-6032.
Questions on this form? Call 888-247-9311 (option 3)

INSTRUCTIONS:

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

 Billing Intermediary Name

 Billing Intermediary's Submitter ID (If already established)

ID# _____ NAME: _____

 ValueOptions ID of the provider on whose behalf you are billing and Legal Name of Provider's Organization

 Address Line 1

 Address Line 2

 City State Zip Code

(_____) _____ (_____) _____
 Telephone Number Fax Number

 Contact person at Billing Intermediary

 Contact E-mail address @

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

- Electronic Claims Submission Single Claims Submission Online Eligibility Inquiry Online Claim Status Inquiry

Agreement Terms:

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

The person signing this Intermediary Authorization Form on behalf of the provider warrants that he/she has the authority to do so.

Signatures:

 Billing Intermediary's Signature Date

 Provider's Authorizing Signature (Signature authorizing Billing Intermediary to perform designated Services as checked above. This blank may not be signed by an agent of the Billing Intermediary.) Date