

# Quick Reference Guide: Bridge Funding Service Claims Submission

This guide provides a basic overview of the process for submitting claims for bridge services in the ProviderConnect system.

## Questions

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Please contact the following for questions:

If you have programmatic questions about the Bridge Services policies please contact the GHVP Helpdesk at [GH.VP@dbhdd.ga.gov](mailto:GH.VP@dbhdd.ga.gov).

If you have questions related to which location to submit claims from or direct claims entry, please contact the Georgia Collaborative ASO Provider Relations at [georgiacollaborativepr@beaconhealthoptions.com](mailto:georgiacollaborativepr@beaconhealthoptions.com).

If you have questions related to claims payment contact to John Quesenberry at [John.Quesenberry@dbhdd.ga.gov](mailto:John.Quesenberry@dbhdd.ga.gov).

## Claims Guidelines

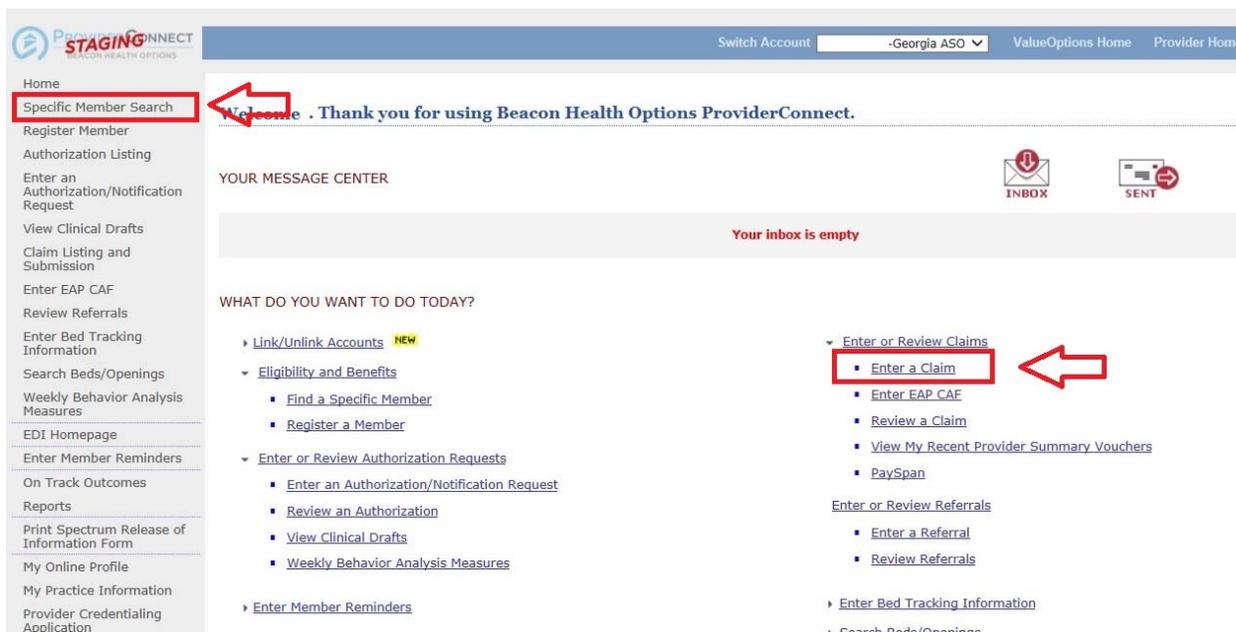
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1. Claims submitted must be in accordance with an approved GHVP-3 form for audit and reconciliation purposes.
2. Newly placed individuals on a housing voucher have available up to \$2500 based on specific need. The provider is allowed an initial fee of \$500. This totals to a maximum of \$3000. Any amount exceeding \$3000 will require special DBHDD approval.
3. Claims will be submitted through the ASO's ProviderConnect direct claims entry process and cannot be submitted via batch because of the receipt requirement.
4. Instead of monthly payments, claims will now be paid weekly. All claims submitted and adjudicated by Beacon's claims staff will be paid with each week's Tuesday check run.
5. Beacon's claims staff will be reviewing submitted receipts. Receipts must be from a valid store, vendor, or business and must have the business name, date of payment, and amount paid. If the receipt is for fees paid to the provider (e.g. Initiation, Renewal, etc.), then an invoice style receipt will be sufficient on agency letterhead or other form with agency name.
6. If items on the receipt are not an approved reimbursable item, draw a line through that items. Ensure the amount on the claim matches the amount to be reimbursed from the receipt.
7. Any claims that have been paid and later it was identified that the expense was outside of the guidelines will require the claim to be reversed and payment recouped.

To access the ProviderConnect Portal use the link below. You must have a User ID and password created by your agency's Super User.

<https://www.valueoptions.com/pc/eProvider/providerLogin.do?client=GACO>

There are two paths to get to the claims entry screen a) by searching for a specific member or b) by selecting the claims link on the landing page. Steps for both are covered below.



If you use Option 2, you will not access the member search functionality and will need to know the member's CID number and date of birth for the claims entry screen.

A list of services and billing codes can be found in Appendix A.

## Option 1: Specific Member Search

1. Once logged into Provider Connect, select the “**Specific Member Search**” link on the left menu bar.



2. At the Eligibility & Benefits Search screen, enter the member specific criteria to search for the individual for which the claim is being submitted and press the “**Search**” button.

*Note: Two of the three items below will be required:*

- *An ID Number (CID, SSN, Medicaid, Medicare)*
- *Date of Birth*
- *Last Name (spelling counts as the search will look for an exact match)*

A screenshot of the 'Eligibility & Benefits Search' form. The left sidebar menu is visible, with 'Specific Member Search' selected. The main content area has the title 'Eligibility & Benefits Search' and a sub-header 'Verify a patient's eligibility and benefits information by entering search criteria below.' Below this, there are five input fields: 'Member ID' (with an asterisk and '(No spaces or dashes)'), 'Last Name', 'First Name', 'Date of Birth' (with an asterisk and '(MMDDYYYY)'), and 'As of Date' (with the value '08242017' and '(MMDDYYYY)'). A 'Search' button is located at the bottom of the form.

- At the Member Demographics tab, select the “Enter a Claim” button at the bottom of the page.

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Demographics Enrollment History COB Benefits Additional Information

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

Individual?		Eligibility	
Individual ID	<b>400034860</b>	Effective Date	<b>07/18/2017</b>
Alternate ID		Expiration Date	<b>07/28/2018</b>
Individual Name	<b>TEST, TEST</b>	COB Effective Date?	<a href="#">View Funding Source Enrollment Details</a>
Date of Birth	<b>12/13/1988</b>		
Address	<b>TEST ATLANTA, GA 30315</b>		
Alternate Address			
Marital Status	-		
Home Phone	<b>123 -123 -1234</b>		
Work Phone			
Relationship	<b>1</b>		
Gender	<b>M - Male</b>		

Subscriber

Subscriber ID	<b>400034860</b>
Subscriber Name	<b>TEST, TEST</b>

Individual Participates in Message Center Communication with Providers? **No**

**If you wish to use the ProviderConnect Message Center to communicate with Individuals who participate in Message Center communication, please update your Profile and conduct a new Individual Search for the Individual you would like to contact.**

- At the Service Address screen, select the appropriate location for Bridge Services to be billed from. Typically, this is the primary address from the Provider’s contract, administrative offices, or other main office location. Please contact the ASO’s Provider Relations Office at [gacollaborativepr@beaconhealthoptions.com](mailto:gacollaborativepr@beaconhealthoptions.com) if you have any questions about which location is currently configured for Bridge Services.

**Provider**

Provider  Provider Last Name **CSB** Provider First Name

**Select Service Address**

Capture	Vendor ID	Service Address	Pay To Address
<input type="radio"/>	GA000000	CSB 1400 MAIN ST MACON, GA 31217	BEHAVIORAL HEALTH CENTER 1400 MAIN ST MACON, GA 31217
<input type="radio"/>	GA000000	CSB GA HIGHWAY12 MILLEDGEVILLE, GA 31061	BEHAVIORAL HEALTH CENTER 1400 MAIN ST MACON, GA 31217

- On the Submit a Claim – Step 1 of 3 screen, the Member ID and Date of Birth will pre-populate. Enter the **First Date of Service** and select “**No**” for the EAP question then press the “**Next**” button.

*Note: The first date of service should reflect the date from the receipt.*

### Submit A Claim - Step 1 of 3

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

To submit a single claim, begin with step 1 below.

Provider Name	CSB
Service Address	1400 MAIN STREET, MACON,GA,31217
Pay To Address	1400 MAIN STREET, MACON,GA,31217
Vendor ID	GA000000
NPI Number	<input type="text"/>
Taxonomy Code	<input type="text"/>
Licensure Level	Select...
*Member ID	<input type="text"/> (X-digits, no spaces or dashes)
Member Name	<input type="text"/> <input type="text"/> (First Last)
Member Account #	<input type="text"/> (X-digits, no spaces or dashes)
Program/Fund/Group ID	<input type="text"/>
*Member DOB	<input type="text"/> (MMDDYYYY)
*First Date of Service	<input type="text"/> (MMDDYYYY - Enter Earliest Date of Service for this claim)
*Is this claim being billed under EAP Services?	<input type="radio"/> Yes <input checked="" type="radio"/> No

- On the Submit a Claim – Step 2 of 3 screen, select the **Frequency Type** (“Original” will be selected for the first time the claim is being submitted). No Prior Authorization number is required for Bridge Service claims. Press the “**Next**” button.

### Submit A Claim - Step 2 of 3

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

Individual ID	Individual Name	Birth Date	NPI Number	Service Address	Pay To Address
400034860	TEST TEST	12/13/1988	1174512966	175 EMERY HWY,MACON,GA,31217	175 EMERY HWY,MACON,GA,31217

Frequency Type:  Select...
 Original Reference Number:    
 Prior Authorization Number:

Only populate **Other Payer Information** fields(s) if Coordination of Benefit (COB) information is applicable to dates of service on this claim. i.e., if any payment from other payer entities were previously applied to this claim.

Does a COB exist for this claim?  
 Yes  No

### Other Payer Information - Primary

### Other Payer Information - Secondary

### Other Payer Information - Tertiary

- On the Submit a Claim – Step 3 of 3 screen, complete the following items:
  - Service Through** (this will be the same as the Service From date)
  - Service Code / Modifiers** (enter the specific code being billed including modifiers)
  - Charge Amount** (this is the dollar amount of the reimbursement for the specific service)
  - Place of Service** (use code '99')
  - Units** (use 1 unit of service)
  - Diagnosis** (use the individual's mental health diagnosis or F99).

Once you have entered all of the above service information, press the **“Add Service Line”** button. This will add the detail line information below in the Ready to Submit section. If you need to add additional service lines to the same claim, fill in the service line entry information for the new claim line and then press the **“Add Service Line”** button. Add additional lines as needed.

**Service Line Entry**

\*Service From: 08012017 (MMDDYYYY)  
 \*Service Through: 08012017 (MMDDYYYY)  
 \*Service Code: T1999 (ex: 86753)  
 Modifier Code 1: HE (no spaces or dashes)  
 Modifier Code 2: (no spaces or dashes)  
 Modifier Code 3: (no spaces or dashes)  
 Modifier Code 4: (no spaces or dashes)  
 NDC Num: (no spaces or dashes)

\*Charge Amount (\$): 156.13 (ex: 123.45)  
 \*Place of Service: 99 (00 – 99)  
 \*Units: 1 (3-digits)

\*Diagnosis Code 1: F99 (ex: 765.4)  
 Diagnosis Code 2: (ex: 765.4)  
 Diagnosis Code 3: (ex: 765.4)  
 Diagnosis Code 4: (ex: 765.4)  
 Diagnosis Code 5: (ex: 765.4)  
 Diagnosis Code 6: (ex: 765.4)  
 Diagnosis Code 7: (ex: 765.4)  
 Diagnosis Code 8: (ex: 765.4)  
 Association: (ex: XZ)

Primary Payer: COB Payer Paid 1 (ex: 99999.99), COB Units Paid 1 (ex: 999)  
 Secondary Payer: COB Payer Paid 2 (ex: 99999.99), COB Units Paid 2 (ex: 999)  
 Tertiary Payer: COB Payer Paid 3 (ex: 99999.99), COB Units Paid 3 (ex: 999)

This will add this service line information to the claim

**Claim Detail: Ready to Submit**

Click to Remove	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	COB Payer Paid	
	Start Date	End Date						Place of Service	Modifier Code 3
<input type="radio"/>	08012017	08012017	T1999 99	HE		156.13	F99		
<b>Total</b>								0.00	0.00

- To attach the associated receipt(s), click the **“Upload File”** button in the Attached an EOB section. (Note: This section is typically used for submitting EOBs on claims but that is not necessary for Bridge Service claims.) When ready to submit claim, press the **“Submit”** button.

To remove a service line, select the "Click to Remove" button for the line needed to be removed, then click the "Remove" button below

**Attach an EOB**

Click Upload File to attach a COB EOB with this claim.

This will attach an EOB document to the claim.

Attached Documents:

This will remove the service line selected above      This will submit the entire claim (including all service lines added)      This will return to the preceding data entry page

9. After you have pressed the “Submit” button, the Submission Results will appear.

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ProviderConnect Home

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**Submit A Claim**

**Submission Results :** \*\*\*\*\* CLAIM ENTERED \*\*\*\*\*

Your claim has been submitted successfully. You may contact Claims Customer Service with any questions related to this claim.

Provider Name/ ID      CSB-GAC000556  
 Vendor ID                GA005468  
 Patient ID                400034860  
 Patient Name            TEST, TEST  
 Program/Fund/Group ID  
 Patient Date of Birth    12/13/1988  
 NPI Number              1174512966  
 Taxonomy Code  
 Licensure Level  
 Prior Authorization Number  
 Claim #                    [082817-04065-00001](#)

Line #	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	COB Payer Paid			To-Pay	Status	Dollar Amount (\$)					Fund	NDC Number	Assc Qual	
	Start Date	End Date						Primary	Secondary	Tertiary			Allowed	Deductible	Pre-Paid	COIN	CoPay				NDC Units/Type
1	08/01/2017	08/01/2017	T1999 99	HE		156.13	F99	0.00	0.00	0.00	0.00	A	0.00	0.00	0.00	0.00	0.00	0.00	GREG		
<b>Total</b>								0.00	0.00	0.00											

Attached EOBs :

No EOB COB Documents Attachments

## Option 2: Enter a Claim Link

1. Once logged into Provider Connect, select the “Enter a Claim” link in the center of the home landing page.



2. At the Service Address screen, select the appropriate location for Bridge Services to be billed from. Typically, this is the primary address from the Provider’s contract, administrative offices, or other main office location. Please contact the ASO’s Provider Relations Office at [gacollaborativepr@beaconhealthoptions.com](mailto:gacollaborativepr@beaconhealthoptions.com) if you have any questions about which location is currently configured for Bridge Services.

**Provider**

Provider  Provider Last Name **CSB** Provider First Name

**Select Service Address**

Capture	Vendor ID	Service Address	Pay To Address
<input type="radio"/>	GA000000	CSB 1400 MAIN ST MACON, GA 31217	BEHAVIORAL HEALTH CENTER 1400 MAIN ST MACON, GA 31217
<input type="radio"/>	GA000000	CSB GA HIGHWAY 12 MILLEDGEVILLE, GA 31061	BEHAVIORAL HEALTH CENTER 1400 MAIN ST MACON, GA 31217

- On the Submit a Claim – Step 1 of 3 screen, enter the **Member ID**, **Date of Birth**, **First Date of Service**, and select “**No**” for the EAP question then press the “**Next**” button.

*Note: The first date of service should reflect the date from the receipt.*

### Submit A Claim - Step 1 of 3

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

To submit a single claim, begin with step 1 below.

Provider Name	CSB
Service Address	1400 MAIN STREET, MACON,GA,31217
Pay To Address	1400 MAIN STREET, MACON,GA,31217
Vendor ID	GA000000
NPI Number	<input type="text"/>
Taxonomy Code	<input type="text"/>
Licensure Level	Select...
*Member ID	<input type="text"/> (X-digits, no spaces or dashes)
Member Name	<input type="text"/> <input type="text"/> (First Last)
Member Account #	<input type="text"/> (X-digits, no spaces or dashes)
Program/Fund/Group ID	<input type="text"/>
*Member DOB	<input type="text"/> (MMDDYYYY)
*First Date of Service	<input type="text"/> (MMDDYYYY - Enter Earliest Date of Service for this claim)
*Is this claim being billed under EAP Services?	<input type="radio"/> Yes <input checked="" type="radio"/> No

- On the Submit a Claim – Step 2 of 3 screen, select the **Frequency Type** (“Original” will be selected for the first time the claim is being submitted). No Prior Authorization number is required for Bridge Service claims. Press the “**Next**” button.

### Submit A Claim - Step 2 of 3

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

Individual ID	Individual Name	Birth Date	NPI Number	Service Address	Pay To Address
400034860	TEST TEST	12/13/1988	1174512966	175 EMERY HWY,MACON,GA,31217	175 EMERY HWY,MACON,GA,31217

Frequency Type:  Select...  
 Original Reference Number:      
 Prior Authorization Number:

Only populate **Other Payer Information** fields(s) if Coordination of Benefit (COB) information is applicable to dates of service on this claim. i.e., If any payment from other payer entities were previously applied to this claim.

Does a COB exist for this claim?  
 Yes  No

#### Other Payer Information - Primary

#### Other Payer Information - Secondary

#### Other Payer Information - Tertiary

- On the Submit a Claim – Step 3 of 3 screen, complete the following items:

- **Service Through** (this will be the same as the Service From date)
- **Service Code / Modifiers** (enter the specific code being billed including modifiers)
- **Charge Amount** (this is the dollar amount of the reimbursement for the specific service)
- **Place of Service** (use code '99')
- **Units** (use 1 unit of service)
- **Diagnosis** (use the individual's mental health diagnosis or F99).

Once you have entered all of the above service information, press the **"Add Service Line"** button. This will add the detail line information below in the Ready to Submit section. If you need to add additional service lines to the same claim, fill in the service line entry information for the new claim line and then press the **"Add Service Line"** button. Add additional lines as needed.

**Service Line Entry**

\*Service From: 08012017 (MMDDYYYY) | \*Service Through: 08012017 (MMDDYYYY) | \*Service Code: T1999 (ex: 86753) | Modifier Code 1: HE (no spaces or dashes) | Modifier Code 2: | Modifier Code 3: | Modifier Code 4: | NDC Number: | (no spaces or dashes)

\*Charge Amount (\$): 156.13 (ex: 123.45) | \*Place of Service: 99 (00 - 99) | \*Units: 1 (3-digits) | NDC Units: | (ex: 765.4 OR 765.0)

\*Diagnosis Code 1: F99 (ex: 765.4) | Diagnosis Code 2: | (ex: 765.4) | Diagnosis Code 3: | (ex: 765.4) | Diagnosis Code 4: | (ex: 765.4) | Diagnosis Code 5: | (ex: 765.4) | Diagnosis Code 6: | (ex: 765.4) | Diagnosis Code 7: | (ex: 765.4) | Diagnosis Code 8: | (ex: 765.4) | Association Qualifier: | (ex: XZ)

Primary Payer: COB Payer Paid 1: | (ex: 99999.99) | COB Units Paid 1: | (ex: 999) | Secondary Payer: COB Payer Paid 2: | (ex: 99999.99) | COB Units Paid 2: | (ex: 999) | Tertiary Payer: COB Payer Paid 3: | (ex: 99999.99) | COB Units Paid 3: | (ex: 999)

This will add this service line information to the claim

**Claim Detail: Ready to Submit**

Click to Remove	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	COB Payer Paid		
	Start Date	End Date	Place of Service	Modifier Code 3	Modifier Code 4		Primary	Secondary	Tertiary	
<input type="radio"/>	08012017	08012017	T1999 99	HE		156.13	F99			
<b>Total</b>								0.00	0.00	0.00

- To attach the associated receipt(s), click the **"Upload File"** button in the Attached an EOB section. (Note: This section is typically used for submitting EOBs on claims but that is not necessary for Bridge Service claims.) When ready to submit claim, press the **"Submit"** button.

To remove a service line, select the "Click to Remove" button for the line needed to be removed, then click the "Remove" button below

**Attach an EOB**

Click Upload File to attach a COB EOB with this claim.

This will attach an EOB document to the claim.

Attached Documents:

This will remove the service line selected above | This will submit the entire claim (including all service lines added) | This will return to the preceding data entry page

- After you have pressed the **"Submit"** button, the Submission Results will appear.

Submit A Claim

Submission Results : \*\*\*\*\* CLAIM ENTERED \*\*\*\*\*

Your claim has been submitted successfully. You may contact Claims Customer Service with any questions related to this claim.

Provider Name/ ID           CSB-GAC000556  
 Vendor ID                   GA005468  
 Patient ID                  400034860  
 Patient Name                TEST, TEST  
 Program/Fund/Group ID  
 Patient Date of Birth       12/13/1988  
 NPI Number                 1174512966  
 Taxonomy Code  
 Licensure Level  
 Prior Authorization Number  
 Claim #                     [082817-04065-00001](#)

Line #	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	COB Payer Paid			To-Pay	Status	Dollar Amount (\$)					Fund	NDC Number	Assc Qual
	Start Date	End Date						Place of Service	Modifier Code 3	Modifier Code 4			Primary	Secondary	Tertiary	Allowed	Deductible			
1	08/01/2017	08/01/2017	T1999 99	HE		156.13	F99	0.00	0.00	0.00	0.00	A	0.00	0.00	0.00	0.00	0.00	GREG		
<b>Total</b>								0.00	0.00	0.00										

Attached EOBs :  
 No EOB COB Documents Attachments

[Enter New Claim](#)

## Appendix A: Services and Procedure Codes

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The table below provides a list of services that can be billed for Bridge Services and the associated billing procedure code.

<b>Service Name</b>	<b>Procedure Code</b>	<b>Modifier 1</b>	<b>Modifier 2</b>	<b>Modifier 3</b>	<b>Modifier 4</b>
Household Furnishings	T1999	HE	H1		
Household goods and Supplies	T1999	HE	H2		
Moving Expenses	T1999	HE	M1		
Utility Deposits	T1999	HE	D1		
Security Deposits	T1999	HE	S1		
Transportation	T2003	HE			
Environmental Modifications	S5165	HE			
Food/Grocery	T1999	HE	FG		
Medication	T1999	HE			
Rent Payment	H0044	HE			
Fees - Initiation	T1999	HE	F1		
Fees - Renewal	T1999	HE	F2		
Fees - Transfer	T1999	HE	F3		
Other	T1999	HE	X1		

Note: Some modifiers are non-traditional and created for the purpose of state use only.