PROVIDER PRACTICE PORTAL ACCESS REGISTRATION FORM

ORGANIZATION INFORMATION			
Organization Name (As listed on W-9)	How many providers in group?	Organization NPI:	TAX ID (Billing TIN):
Organization Address	City	State	Zip Code

AUTHORIZED OFFICIAL FOR THE ORGANIZATION

Each Tax ID number can only have one administrator whose responsibility it is to notify AAMG/CCHCA of portal user additions, changes and terminations. Please name an administrator for the TIN above:

Authorized Official for the Organization: Name:_____ Title: _____ **(ex: Owner, Executive, President, Director, or Administrator)**	Representative Email:	Representative Phone:

ADMINISTRATOR USER INFORMATION

In the section below, identify the authorized individual who will manage USER ACCESS to the Provider Portal. Individuals using the portal must include email/phone number to receive a user name and password. User name and password will be emailed to individual. User names and passwords must not be shared.

Name	Email
Title	Phone

Access Level Designation to Authorized User:

- ❑ Claims Status
- ❑ Manage User Access (usually administrator)
- ❑ Eligibility
- ❑ Submit Authorizations
- ❑ Read Only - Authorizations

By signing this form, the Administrator has agreed to the sole responsibility on behalf of all of the users above that are given access to the Provider Portal eligibility and claim information. The Administrator also agrees to ensure that all users above are trained to handle Protected Health Information (PHI) and Electronic Protected Health Information (ePHI) documents prior to exposure of the Provider Portal, along completing the required annual trainings provided by CMS: Health Insurance Portability and Accountability Act (HIPAA) and Fraud, Waste, and Abuse (FWA).

BOTH SIGNATURES ARE REQUIRED

_____ Date_____

Administrator Signature & Title

_____ Date_____

Provider/Authorized Official Signature & Title

ADDITIONAL USER(s) INFORMATION

In the section below, identify the individuals who will need access to the Provider Portal. All individuals using the portal must include email/phone number to receive a user name and password. User names and passwords will be emailed to individual user. User names and passwords must not be shared.

User	Access Level
User Name (Last, First) ______________________________ Email ____ Phone _____________________________	**ACCESS LEVEL:** ❑ Claims Status ❑ Eligibility ❑ Submit Authorizations ❑ ***Read Only*** - Authorizations
User Name (Last, First) ______________________________ Email ____ Phone _____________________________	**ACCESS LEVEL:** ❑ Claims Status ❑ Eligibility ❑ Submit Authorizations ❑ ***Read Only*** - Authorizations
User Name (Last, First) ______________________________ Email ____ Phone _____________________________	**ACCESS LEVEL:** ❑ Claims Status ❑ Eligibility ❑ Submit Authorizations ❑ ***Read Only*** - Authorizations
User Name (Last, First) ______________________________ Email ____ Phone _____________________________	**ACCESS LEVEL:** ❑ Claims Status ❑ Eligibility ❑ Submit Authorizations ❑ ***Read Only*** - Authorizations
User Name (Last, First) ______________________________ Email ____ Phone _____________________________	**ACCESS LEVEL:** ❑ Claims Status ❑ Eligibility ❑ Submit Authorizations ❑ ***Read Only*** - Authorizations

Make additional copies as needed.

FAX COMPLETED APPLICATION TO: 415-216-0081 OR 888-327-1168

Disclaimer: Privacy / User Responsibilities/ Terms and Conditions of Use

AAMG/CCHCA/FYB is collecting your information on this form in order to authorize Providers and delegates (provider staff or authorized business associate) to access the Provider Portal. Any personal information you provide to AAMG/CCHCA/FYB will be kept confidential and secure. AAMG/CCHCA/FYB will not use any of your personal information for any other purpose, or disclose your personal information to any other organizations or individuals, unless authorized or required by law or you provide your consent to do so.

All users have a responsibility to ensure their username and password are secure and not being shared with others. Users must only access information that they have been authorized to use. Manager or proprietor who authorizes user access is held responsible for the conduct of their user(s), and must ensure compliance with HIPAA Privacy and Security and HITECH Act, as well as ensure all required trainings are provided prior to user(s) exposure to the Provider Portal.

Manager or proprietor who authorizes user access is REQUIRED to notify user access termination to AAMG/CCHCA/FYB Provider Relations Department immediately upon user's separation of the company to ensure compliance with HIPAA Privacy and Security.