Provider Tools and Electronic Data Submission Enrollment Form

fallon community health plan

If you would like secure access to Fallon Community Health Plan's (FCHP) Provider Tools on fchp.org, please have your office manager fill out the form below. Upon receipt and review by FCHP, your assigned username and password will be forwarded to each authorized individual. If you do not hear back from us within 15 business days, please call 1-866-ASK-FCHP (1-866-275-3247), to confirm receipt.

Provider information		
Vendor/provider/facility name:		NPI #: (required)
Provider mailing address (line 1):		
Provider mailing address (line 2):		
City:	State:	ZIP:
Telephone number:		Fax number:
Vendor contact name/title/phone number:		Vendor contact e-mail address:
IT contact name/title/phone number:		IT contact e-mail address:

Access to PCP panel reports	
If you would like multiple users to have access to **PCP panel reports**, please fill out the information below. List the name and NPI number of each user in the office/group.	
Name:	NPI #:
Name:	NPI #:
Name:	NPI #:
Name:	NPI #:
Name:	NPI #:

Provider tools user authorization

Below, list the employees to be granted access to Provider Tools through fchp.org. To request access to Provider Tools for third-party agencies, complete the Billing Agency Authorization Form in addition to this form.

Employee name and e-mail address (required)	**Keyword for forgotten password** (required; must be unique for each individual)	**Provider tools** (please indicate the type of access you are requesting by checking the corresponding box)			
		PCP panel reports (PCPs only)	**Provider referral monitoring report** (PCPs only)	**Claims metric reports** (contracted providers only)	**Eligibility verification**
Name: / **E-mail:**		☐	☐	☐	☐
Name: / **E-mail:**		☐	☐	☐	☐
Name: / **E-mail:**		☐	☐	☐	☐
Name: / **E-mail:**		☐	☐	☐	☐

Provider Tools and Electronic Data Submission Enrollment Form, *continued*

FCHP uses secure file transfer via the Web. All files to and from FCHP will be transferred via https. Please ensure that your office browser supports SSL and is able to handle 128-bit encryption. It is recommended for transferring files of 10 MB or less.

Electronic Data Submission method (to be filled out if exchanging transactions such as the 837)			
Information regarding file transfers to FCHP			
If submitting files to FCHP, what is the average size of the files?			
How often will files be submitted ?	☐ Daily	☐ Weekly	☐ Monthly
How many files—on average—will be submitted?			
For information about FCHP's naming convention for HIPAA transaction sets, please view our EDI Companion Guides (http://www.fchp.org/Extranet/Providers/EDI_companion_guides.htm).			

If you are interested in SFTP access, please request a separate form from FCHP's EDI Coordinators at 1-866-ASK-FCHP (1-866-275-3247), ext. 69968.

Agreement terms

I will protect all usernames and passwords given to me during this registration process from unauthorized use and disclosure. I understand that I am responsible for all actions performed while accessing FCHP Provider Tools. I will notify Fallon Community Health Plan immediately by calling 1-866-ASK-FCHP (1-866-275-3247), if I believe a password has been compromised. **I will notify FCHP to disable access when an employee's responsibilities no longer require using Provider Tools, or when an employee terminates.**

I understand that as the provider of health care services or trading partner or delegate, I am responsible for compliance with all federal and state requirements regarding the confidentiality of health care information, and that I have responsibility for the actions and use of that information for those users I have designated access. The undersigned agrees to indemnify and hold harmless FCHP for any breach of this confidentiality agreement, and shall be liable to FCHP for any such breach of this agreement and damages resulting from such breach, including but not limited to, interference and contractual relations, interference with advantageous relations, loss of any contract and any other losses and/or damages together with FCHP's expenses in connection with the breach, including but not limited to costs, accountant fees, consultant fees and reasonable attorney's fees.

I authorize FCHP to receive and process EDI transactions in accordance with applicable regulations. I assure that all information submitted is accurate and any claims submitted in falsification are prosecutable under state and/or federal laws.

All information provided on the FCHP site is accurate to the best of our knowledge. FCHP shall not be liable for any claims, loss or damage resulting from its use.

Signatures		
Legal name of vendor organization:		
Individual authorized to sign for organization/title:	Individual's authorizing signature:	Date:

Billing Agency Authorization Form

fallon community health plan

To grant secure access to a third party billing agency to Fallon Community Health Plan's (FCHP) Provider Tools on www.fchp.org, please fill out the form below. **Please note: The signature of the requesting provider is required to allow access to a third party billing agency.** Upon receipt and review by FCHP your assigned username and password will be forwarded to each authorized individual. If you do not hear back from us within 15 business days, please call 1-866-ASK-FCHP (1-866-275-3247) to confirm receipt.

Billing agency information		
Billing agency name:	NPI # of provider being represented:	
Street address (line 1):		
Street address (line 2):		
City:	State:	ZIP:
Telephone number:	Fax number:	
Billing intermediary contact name/title:	Billing intermediary contact e-mail address:	

User authorization			
Below, please indicate the level of access allowed for the above named, third-party billing agency.			
Employee name and e-mail address (required)	**Keyword for forgotten password** (required; must be unique)	**Claims metric reports**	**Eligibility verification**
Name:		☐	☐
E-mail:			

Agreement terms

The undersigned provider authorizes the above-named billing agency access to FCHP Provider Tools on fchp.org to submit data to FCHP on the provider's behalf. As such, the provider accepts full liability for all actions of the above named billing agency and is responsible for any violations of laws and regulations.

I will protect all usernames and passwords given to me during this registration process from unauthorized use and disclosure. I understand that I am responsible for all actions performed while accessing FCHP Provider Tools. I will notify FCHP immediately by calling 1-866-ASK-FCHP (1-866-275-3247) if I believe a password has been compromised. **I will notify FCHP to disable access when an employee's responsibilities no longer require using FCHP Provider Tools or when an employee terminates.**

I understand that as the provider of health care services or trading partner or delegate, I am responsible for compliance with all federal and state requirements regarding the confidentiality of health care information, and that I have responsibility for the actions and use of that information for those users I have designated access. The undersigned agrees to indemnify and hold harmless FCHP for any breach of this confidentiality agreement, and shall be liable to FCHP for any such breach of this agreement and damages resulting from such breach, including but not limited to interference and contractual relations, interference with advantageous relations, loss of any contract and any other losses and/or damages together with FCHP's expenses in connection with the breach, including but not limited to costs, accountant fees, consultant fees and reasonable attorney's fees.

I authorize FCHP to receive and process EDI transactions in accordance with applicable regulations. I assure that all information submitted is accurate and any claims submitted in falsification are prosecutable under state and/or federal laws.

All information provided on the FCHP site is accurate to the best of our knowledge. FCHP shall not be liable for any claims, loss or damage resulting from its use.

Signatures		
Authorizing provider signature:		
Legal name of vendor organization:		
Individual authorized to sign for vendor organization/title:	Individual's authorizing signature:	Date:
Billing agency name/title:	Billing agency signature:	Date: