Referral Portal Access Form

HealthPlans, Inc.

Introduction

Health Plans, Inc. is pleased to offer access to the Referral Portal designed to assist you with submitting referrals for the Boston Medical Center Employee Group Health Plan (the Plan). Before submitting this form, please consider which staff in your organization have a legitimate business need to access this tool to submit referrals. This form provides you with the necessary steps to authorize such individuals for access to the referral portal and the ability to submit, change or cancel referral submissions.

Section A – Terms of Access

Completion of this form is the first step required for the individual designated below to receive a temporary password and instructions for logging in, changing their password and accessing the Referral Portal. By completing and signing this form, you are verifying that:

1. You have authorized the designated employee(s) listed below to have access to the Referral Portal in order to perform necessary administrative functions to submit referrals for the Boston Medical Center Employee Group Health Plan.

2. You have provided the designated employees with appropriate privacy and security training and received reasonable assurances that:
   a) The designated employees will *only* use or disclose PHI as permitted or required by law;
   b) The designated employees will *not* use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employer benefit plan;
   c) The designated employees will report to the Health Plans any use or disclosure of PHI that s/he becomes aware of which is inconsistent with the uses and disclosures provided for;
   d) The designated employees will use appropriate and reasonable safeguards to protect the confidentiality, integrity and availability of PHI used, disclosed, created, received, maintained, or transmitted;
   e) The designated employees will promptly report to Health Plans any use or disclosure of PHI that is made in violation of or is inconsistent with the HIPAA Rules;

3. You will limit the designated employees' access to the minimum amount of PHI necessary to accomplish the intended business purpose for which the access is needed;
   a) Health Plans is not responsible to determine whether the requested access is the minimum amount necessary and such determination is solely made by the Plan Sponsor (or designee); and
   b) Health Plans may rely on the request for access to the Referral Portal as being the minimum necessary amount needed for the intended business purpose in accordance with the HIPAA Rules.

4. You will report any and all changes to the below listing of designated employees to Health Plans in a timely manner.

Section B – Authorizing Provider Organization

The following provider organization has requested access to the Health Plans Referral Portal to submit referrals for the Boston Medical Group Health Plan. Please complete the following:

Provider Organization: Provider TIN:

Practice or Office Manager Contact:

Continued on reverse

Referral Portal Access Form (continued)

Section C – Referral Portal Users

The following employees require access to the Health Plans Referral Portal to submit referrals for the Boston Medical Group Health Plan. Please complete the following:

1. Employee Name: Title:
   Email Address:

2. Employee Name: Title:
   Email Address:

3. Employee Name: Title:
   Email Address:

4. Employee Name: Title:
   Email Address:

5. Employee Name: Title:
   Email Address:

To set up access to the Referral Portal, Health Plans will send a temporary password via secure email, to the individual listed above. The subject line of this email will be PGP Universal Secured Message. Only ONE user per password is allowed. Once the individual has received a temporary password, he or she can contact Health Plans if further assistance in accessing the portal is needed.

Section D - Authorization

Signature:

Print Name:

Title: Date:

RETURN FORM

Please return all pages of this form to verify your agreement with the statements in Items 1-4 under Section A.
Completed form(s) should be returned to healthplansreferralrequest@healthplansinc.com