Revised 08/03/15

Print Form

Email Form

CLAIMS/ELIGIBILITY WEB PORTAL AGREEMENT

I, the undersigned, request Super User access to the Community Health Options web portal on behalf of the provider office or facility shown below for the purposes of: (1) verifying Community Health Options member eligibility, (2) verifying the status of claims submitted to Community Health Options with dates of service on or after January 1, 2014 and (3) other functionality that may be provided in the future.

As part of this access, I acknowledge and agree to the following terms and conditions:

(1) To assign a portal administrator to be responsible for adding, changing, and terminating portal access as staff turn-over occurs for the staff and employees of this organization.

(2) To ensure that terminated or resigning staff or employees have their access to the portal de-activated concurrent with their departure from our organization.

(3) To ensure with all reasonable and effective efforts that the information contained in the portal will be treated as confidential and used solely for purposes authorized by applicable laws, rules and regulations, including, but not limited, the Health Insurance Portability and Accountability Act with regard to Personal Health Information.

(4) To notify Community Health Options Provider Relations immediately of a change in this organization's assigned portal administrator.

(5) Subsequent to initial set-up and training of applicable staff by Community Health Options, to ensure that new or additional staff or employees given access to the portal by this organization are trained on how to use the portal using training materials provided by Community Health Options.

Portal Administrator Name(printed): _____ _____ Date: _____

Portal Administrator Signature

Practice or Facility Name: _____

Portal Administrator Telephone: _____ Portal Administrator Email: _____

FAX THIS FORM TO 207-402-3751 or MAIL TO:

ATTN: PROVIDER RELATIONS
COMMUNITY HEALTH OPTIONS
P.O. BOX 1121
LEWISTON, ME 04243-1121

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WEB PORTAL SIGN-UP INFORMATION FORM

(Please Print Clearly)

To assure correct set up and easy access to the Web Portal, please provide Community Health Options with the information below and return with your signed Web Portal Agreement.

Web Portal Sign-Up Information

Tax ID:		Phone:			
Address:					
City:		State:		Zip Code:	

Employee Roles

Back Office: *claim status only* ***Front Desk:*** *eligibility only* ***Provider User:*** *both claim and eligibility*
Super User: *all functions, including adding & removing new employees and password resets*

Employee Name:		Employee Email:		
Please select employee role:	☐ Back Office	☐ Front Desk	☐ Provider User	☐ Super User

Employee Name:		Employee Email:		
Please select employee role:	☐ Back Office	☐ Front Desk	☐ Provider User	☐ Super User

Employee Name:		Employee Email:		
Please select employee role:	☐ Back Office	☐ Front Desk	☐ Provider User	☐ Super User

Employee Name:		Employee Email:		
Please select employee role:	☐ Back Office	☐ Front Desk	☐ Provider User	☐ Super User

Employee Name:		Employee Email:		
Please select employee role:	☐ Back Office	☐ Front Desk	☐ Provider User	☐ Super User

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