DRISCOLL HEALTH PLAN
Provider PORTAL AGREEMENT

I, the undersigned, request access to the Driscoll Health Plan (DHP) Provider portal on behalf of the provider office or facility shown below for the purposes of: (1) verifying DHP member eligibility, (2) verifying the status of claims submitted to DHP, and (3) other functionalities 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 shall 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 the Provider Relations Department immediately of a change in this organization's assigned portal administrator.

(5) Subsequent to initial set-up and training of applicable staff by DHP, 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 DHP.

Signed by: ____ Date: ______________________

Printed Name of Signer: ____

Practice or Facility Name: ____

Portal Administrator: ____

E-Mail Address of Portal Administrator: ____

Telephone Number of Portal Administrator: ____

TAX ID: _____________________________

Fax completed form to 361-881-1349 **OR** 956-992-0392

A friend of the family

Provider Portal Sign up Information Form

The purpose of this form is to provide Driscoll Health Plan with the names and emails of your staff in order to create usernames for access to our Provider Portal (www.driscollhealthplan.com). In addition to accessing the site, your staff will be able to utilize various links based on your determination of need. If you need help with completing this form, contact Provider Relations at: (956) 632-8308 or (361) 694-6554

To assure correct set up and easy access to the Provider Portal, please provide Driscoll Health Plan with the information below and return with your signed Web Access Agreement

Practice name: ____

Address: ____

TAX ID: ______________

Phone#: ______________

Fax#: ______________

Primary Contact Person: ____

Primary Email Address: ____

Determine which links your staff needs:

Online Access THSteps, EOP, Provider Panel	Web Portal Claims, Eligibility, Profiles	Online Authorizations	Claims Portal Claims Submission/Emdeon	Vital Data/DR Link HEDIS, Vital Data Summary

Online Access Print or save your EOP's, review panel rosters, and check THSteps eligibility
Web Portal Claims status and Eligibility verification
Online Authorizations Submit authorization and referral request and check status on pending authorizations
Claims Portal Third-Party vendor contracted to provide electronic billing services (fees apply)
Vital Data Quality and clinical data for physicians, clinical staff, and office managers

Provide the name and email for each user and identify which links they will need access to:

	Online Access	Web Portal	Online Authorization	Claims Portal	Vital Data
NAME					
EMAIL					

NAME					
EMAIL					

NAME					
EMAIL					

NAME					
EMAIL					

NAME					
EMAIL					

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