Baptist Health Plan Secure Portal Provider Access Request Form

Please fax to Baptist Health Plan's Provider Services Department:
Lexington 859.335.3736

WARNING: Please note that by granting access to the secure portal, they may be able to view information that is considered Protected Health Information (PHI) under the federal law known as HIPAA.

NOTE: The secure portal is a service provided to participating providers only. If you are interested in participating with Baptist Health Plan, please call our Provider Relations Department at 800.787.2680 or 859.269.4475.

By signing this document, the authorized user agrees to the following terms and conditions of use:

1) Agrees that the Practice Administrator is duly authorized to act as a representative of the Group for the purposes of this Agreement
2) Understands that the information the authorized user will receive through the use of the secure portal is confidential and shall not be disclosed to anyone other than the listed User
3) Agrees to maintain the confidentiality of the account information including password
4) Understands that the Practice Administrator (PA) will be responsible for enrolling additional Users under the Group and distributing User IDs and passwords, and will also be responsible for terminating Users as necessary
5) Understands that Users will have access to the secure portal from any internet-connected computer, regardless of location, and
6) Understands and agrees that any failure to maintain the confidentiality of user information and/or the information made available to Group through the secure portal will subject the Group to civil and criminal liability.

Baptist Health Plan may revoke access to the secure portal at any time if they believe it is being misused.

Additional information regarding functions available on the secure portal will be included in the notification of enrollment into the system, which will be mailed to the attention of the Practice Administrator at the practice's physical address. Two notices will be issued under separate cover, User ID and password, respectively.

Please complete the following (please print):

Practice Administrator: _____ Date: _____

E-mail address: _____

Provider Name: _____ Phone: _____

Provider or Provider Group's Tax ID Number: _____

BAPTIST HEALTH PLAN®

Individual Providers Affiliated With Group:

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

I, as a duly authorized representative of my physician group, acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of the secure portal and consent on behalf of Group to the conditions outlined herein. In addition, I agree to any alterations and/or modifications to these conditions that Baptist Health Plan may impose.

Practice Administrator Signature: **Date:**

Please keep a copy of this form for your own records.

**It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. Ky.Rev.Stat. § 304.47-020; Ind.Code § 35-43-5-3.4.*

It is additionally a crime to knowingly or intentionally obtain, possess, transfer, or use the identifying information of another person with intent to harm or defraud another person or entity, including with the intent to fraudulently obtain or attempt to obtain money, credit, goods, services or medical information in the name of another person without that person's consent. Penalties include imprisonment, fines and denial of insurance benefits. Ky.Rev.Stat. § 514.160; Ind.Code 35-43-5-3.5.