

UPMC Health Plan Provider OnLine Application Process

A. UPMC Health Plan Provider OnLine Policy

- Use of the Web application is restricted to UPMC Health Plan participating providers and their authorized agent (security officer) regarding matters pertaining to security, named user account administration, and other matters related to provider's user of the application.

B. Establishing Access for Your Office

- The provider must sign the Provider OnLine Agreement (pages 1 to 2), thereby designating a security officer (self or other). **This agreement requires signatures for the participating provider and the security officer** (i.e., if the office manager will be serving as security officer, page 2 requires signatures of both the provider and the office manager).
- The security officer must authorize (sign) and submit a Confidentiality Statement (Exhibit A) for each new user. Each user must also sign his or her Confidentiality Statement. The security officer should circle yes to #7B when completing his or her own Confidentiality Statement.

C. New Users to Existing Accounts

- We require the security officer to authorize (sign) and submit a completed Confidentiality Statement (Exhibit A) for each new individual user. Each user must also sign his or her Confidentiality Statement.

D. Changing Security Officers

- The provider and new security officer **must** sign and submit a new agreement (pages 1 to 2).
- The new security officer **must** complete and sign Exhibit A and circle yes to question #7B.
- **One security officer is permitted per Provider**, unless additional officers are approved by your Network manager.

E. Password Resets and Changes

- After three unsuccessful attempts at login, the user will be locked out of the application and will need to contact UPMC Health Plan to re-establish access.
- Individual users or security officers can request password resets and changes by calling the Help Desk at 1-800-937-0438 or e-mailing HPOnline@upmc.edu.

Please mail all documents to: UPMC Health Plan Provider Web Agreements
One Chatham Center, 5th Floor
112 Washington Place
Pittsburgh, PA 15219-9536

Incomplete submissions will be returned.

New User Confirmation Forms will be provided to the security officer either via your Network manager or by mail. Please allow 2 to 4 weeks.

UPMC Health Plan Provider OnLine Web Application

Step-by-Step Instructions for Completion

Page 1: Provider Agreement

1. Enter the practice/facility name. If this is an individual provider, enter the provider's name.

Page 2: Provider Agreement

1. Enter the practice/facility name. If this is an individual provider, enter the provider's name.
2. Enter the name of provider participating (and credentialed) with UPMC Health Plan. This may be a provider who falls under the practice/facility or an individual provider in a private practice.
3. Enter the title of the provider listed in #2.
4. Enter the street address of the practice/facility/provider location.
5. The provider listed above MUST sign here.
6. Enter provider's phone number.
7. Enter the name of the individual the provider wishes to designate as security officer. The provider may elect to designate himself or herself as security officer.
8. Enter the security officer's title.
9. Enter the city, state, and zip code of the practice/facility/provider location.
10. The individual that has been designated as the security officer MUST sign here.
11. Enter security officer's phone number.
12. Enter the Tax ID number that corresponds to the practice/facility/provider name entered in #1.
13. Enter the date that the security office signed this application.
14. Make no entry here. This will be completed by the UPMC Health Plan staff.
15. Make no entry here. This will be completed by the UPMC Health Plan staff.

Page 3: Exhibit A – This form MUST be completed by each individual that is requesting POL access. Use separate form for each user.

1. Enter the practice/facility/provider name here. This should be the same name entered on page 1, #1.
2. If user currently has a Provider OnLine account for any other provider(s), please state their USERID.
3. Enter the name and title of the user for whom you are requesting POL access.
4. Enter the name of the individual designated on the agreement as the security officer by the Provider.
5. The individual user for whom you are requesting POL access MUST sign here.
6. The security officer MUST sign here.
7. Enter the SSN (last four digits) of the user for whom you are requesting POL access.
8. Enter the date of form completion.
9. Enter the user's phone number.
10. Enter the Tax ID number here. This should be the same number entered on page 2, #12.
11. Enter the user's e-mail address.
12. Enter the practice/facility/provider address here. Include the street address, city, state, and zip code.
13. Enter the practice/facility/provider number(s) here, if applicable. This should be the six (6) digit provider number assigned by UPMC Health Plan. NOTE: If you are completing this application during the credentialing process and have not yet received a provider number, please call Provider Services at (888) 876-2756.
14. Make no entry here. This will be completed by the UPMC Health Plan staff.

Page 4: Exhibit B - UPMC Health Plan OnLine User Access Termination Request

This form is used to terminate the POL access of ALL users who no longer require access or who leave the practice/facility or provider.

1. Enter the practice/facility/provider name here. This should be the same name entered on page 1, #1.
2. Enter the Tax ID number here. This should be the same number entered on page 2, #12.
3. Enter the name of the user for whom you are terminating access.
4. Enter the USERID (as assigned by UPMC Health Plan) of the user for whom you are terminating access.
5. Enter the date that you wish to terminate user's POL access.
6. Enter the security officer's name.
7. Enter the security officer's title.
8. Enter the security officer's phone number.
9. The security officer MUST sign here.
10. Enter the date of form completion.

UPMC Health Plan Provider OnLine Web Application Provider Agreement

This UPMC Health Plan Web Application Provider Agreement (“Agreement”) is made and entered into as of the date set forth below, by and between _____ 1 _____ (“Provider”) and UPMC Health Plan, Inc. (“UPMCHP”).

WHEREAS, UPMCHP and Provider have previously entered into, either directly or through a designee, a UPMCHP Provider Agreement, i.e., Hospital Service Agreement, Physician Participation Agreement, Network Master Agreement, UPMC Ancillary Agreement, Provider Organization Agreement, or other similar agreement (“Provider Agreement”); and

WHEREAS, the Provider desires to perform and UPMCHP desires that Provider perform certain customer service functions for persons covered under the Provider Agreement (“Covered Persons”); and

WHEREAS, UPMCHP has developed an online provider services Web application (“Application”) to enable the Provider to access certain confidential Covered Person specific information (“CPI”); and

WHEREAS, UPMCHP and the Provider wish to set out their respective rights and responsibilities under this Application; and

WHEREAS, the parties desire to memorialize obligations of this Agreement pursuant to the terms and conditions set forth in this Agreement.

NOW THEREFORE, in consideration of the mutual covenants and promises herein contained, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereby agree as follows:

1. Terms and Conditions.

- a. The Provider acknowledges and agrees that the Application will allow the Provider to access CPI. Provider represents and warrants that the Covered Persons whose CPI it seeks to access have consented to such access; agrees to keep confidential all CPI obtained regarding Covered Persons; and agrees not to divulge any CPI to any person or entity without the express written consent of the Covered Person whose CPI has been accessed.
- b. The Provider acknowledges and agrees that access to the Application will be provided on a named user basis to specific employees and agents of the Provider (hereinafter, “Named Users”), and not to departments or positions. The Provider shall remain responsible for limiting access to Named Users and for monitoring such access on a regular basis. In the event of a change in or termination of a Named User, the Provider shall immediately notify UPMCHP of same by completing the UPMC Health Plan OnLine User access Termination Request, attached hereto as Exhibit B.
- c. The Provider acknowledges and agrees that UPMCHP is bound by both federal and state laws and regulations, including, but not limited to, HIPAA, to keep CPI confidential. Provider agrees to abide by such laws and regulations, and such additional terms and conditions regarding confidentiality as UPMCHP may require.
- d. The Provider agrees to identify an employee or authorized agent to act as a security officer and primary contact to UPMCHP regarding security, account administration, and other matters related to Provider’s use of the Application. UPMCHP shall provide Provider with written procedures regarding account administration and the use of the Application.
- e. The Provider agrees to instruct all Named Users that CPI may be obtained via the Application only in response to a specific inquiry from a Covered Person.
- f. The Provider acknowledges that the Application permits the Provider and its Named Users to access only the CPI of Provider’s own Covered Persons. Access by Provider or its Named Users to any information related to or concerning persons who are not covered under Provider Agreement is prohibited.
- g. The Provider agrees to adhere to and instruct Named Users in proper security procedures, including, but not limited to, password protection. Provider agrees that only Named Users who have signed Confidentiality Statements in the form attached hereto as Exhibit A will be provided access to the Application, and represents that it has, where necessary and required by HIPAA or other relevant laws or regulations, executed Business Associate or other required agreements with those agents it has identified as Named Users.

- h. The Provider, on behalf of itself, its Named Users, employees, and agents agrees to indemnify, defend, and hold UPMCHP harmless from loss, damage, or liability, including attorneys' fees, that the UPMCHP may suffer by reason of the Provider, its Named Users, employees or agents, or other persons under Provider's control, breaching this Agreement or the confidentiality of any CPI, improperly using any CPI, and/or incorrectly interpreting CPI to any Covered Person. The indemnification provisions of this Agreement shall begin on the effective date of this Agreement and shall cover any and all claims made against UPMCHP as provided herein. These indemnification provisions survive termination of this Agreement.
- i. UPMCHP makes no representations or warranties as to the accuracy or reliability of any conclusions or interpretations regarding CPI obtained from the Application made by Provider or its Named Users.
- j. The Application and any materials related to the Application are the sole and exclusive property of UPMCHP.
- k. UPMCHP reserves the right to alter, amend, modify, terminate, or discontinue the Application, and, if necessary, to gain access to the Application at any time and without notice.
- l. UPMCHP will provide maintenance for and service to the Application.
- m. UPMCHP reserves the right to withdraw or revoke without cause any consent or approval previously granted. Either party may terminate this Agreement without cause by giving the other party thirty (30) days advance written notice.
- n. UPMCHP reserves the right to lock Provider out of Application after ninety (90) days of inactivity. If UPMCHP exercises this right, Provider must contact UPMCHP to re-establish access thereafter. UPMCHP also reserves the right to withdraw Provider's access to the Application altogether after 180 days of inactivity.
- o. Except as otherwise provided herein, Agreement shall not be assigned, delegated, or transferred by Provider without the prior written consent of UPMCHP.
- p. The effective date of this Agreement is the date set forth below regardless of the date it is signed by the parties.
2. **No Other Changes.** Except as changed by this Agreement, all other terms of the Provider Agreement, Exhibits and Attachments remain unchanged and in full force and effect. Termination of the Provider Agreement will immediately terminate this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date written below.

PROVIDER

1	2	3
_____	_____	_____
Print name of Provider/Practice	Participating Provider Name (please print)	Title
4	5	6
_____	_____	_____
Provider/Practice Address	Participating Provider Signature	Phone
7	8	8
_____	_____	_____
	Security Officer Name (please print)	Title
9	10	11
_____	_____	_____
City, State, Zip	Security Officer Signature	Phone
12	13	
_____	_____	
Tax Identification Number	Date	

UPMC Health Plan, Inc.

For UPMCHP Use Only

14	15
_____	_____
Health Plan Representative	Date

EXHIBIT A
CONFIDENTIALITY STATEMENT
USER ACCOUNT AGREEMENT

I have been advised and understand that UPMC Health Plan, Inc. ("UPMCHP") has an agreement ("Agreement") with _____ 1 ("Provider") in which, UPMCHP has agreed to provide the Provider with a Web-based application ("Application") that will enable designated employees and agents of the Provider ("Named Users") to access Provider's Covered Person Information ("CPI") via the Internet. The Application will permit Named Users to perform health care benefits administration for Provider on behalf of Covered Persons. Through my signature below, I represent and warrant that I am lawfully authorized on behalf of the Provider to use the Application and to thereby access the Provider's CPI.

By signing this Statement I understand that:

1. I am being granted access to the Application and CPI.
2. I am obligated to keep the CPI confidential and use such CPI only for work-related activities as directed by the Provider and the Covered Persons.
3. Any work performed under my account and password will be attributed to me.
4. I will not disclose my password or allow any access to the Application by any other person.
5. In the event that I believe that my password may have been learned by any person, I shall immediately notify my security officer and/or UPMCHP and change my password.
6. If I no longer require access to the Application, I will immediately notify my security officer or the Provider.
7. **Access: *Please read carefully to identify the appropriate level of access.**
 - A. **Does user already have access to Provider OnLine for other providers? If yes, USERID _____ 2**
 - B. **Will user be acting as Provider's security officer? (Y or N)**
If yes, please submit Agreement (pages 1 to 2) with appropriate signature (one security officer per Provider, please).
 - C. **Does user require access to view claims for all providers under this Tax ID number? (Y or N)**
If no, please list all applicable provider numbers below in Box 13.
 - D. **Does user require access to submit individual claims using Provider OnLine to UPMCHP? (Y or N)**
If yes, please list all applicable provider numbers below in Box 13.
Note: This does not include batch submission of claims via HIPAA-compliant EDI.
 - E. **Does user require access to view CMS 1500 claims? (Y or N) Does user require access to view UB92 claims? (Y or N)**
 - F. **Does user require access to the low back pain survey? (Y or N)**

User Name and Title (please print) 3		Security Officer Name and Title (please print) 4	
User Signature 5		Security Officer Signature 6	
User SSN (Last 4 digits) 7		Date 8	
User Phone 9		Tax Identification Number 10	
User E-mail Address 11		Provider Address (login will be sent to security officer at this address) 12	
Provider Number(s) if applicable 13			
		<i>For UPMCHP Use Only</i> Vendor # 14	

EXHIBIT B
UPMC Health Plan OnLine User Access Termination Request

Provider Name as shown on the Provider Agreement _____ **1** _____

Tax ID number as shown on the Provider Agreement _____ **2** _____

The following UPMC Health Plan Provider users should be removed from the above provider's access:

User Name _____ **3** _____ User ID _____ **4** _____ Effective date of access termination _____ **5** _____

User Name _____ User ID _____ Effective date of access termination _____

User Name _____ User ID _____ Effective date of access termination _____

User Name _____ User ID _____ Effective date of access termination _____

User Name _____ User ID _____ Effective date of access termination _____

A future effective date may be used if applicable. If no future date is provided, then UPMCHP will use current date.

6

Security Officer Name (please print)

7

Title

8

Phone

9

Security Officer Signature

10

Date