



eCura® ProviderConnect Request for Individual Access

Note: Prior to requesting individual access, **be sure your organization has completed a provider registration that designates a site point of contact.** All requests for individual access must be approved and submitted by the site point of contact. Individual access may be submitted with the Provider Registration.

Instructions:

In order to get an individual account set up to access the eCura® ProviderConnect web site, please do the following:

1. Complete the requested information.

User Agreement

User account set up

Please do not staple these documents prior to mailing.

2. Mail the above two pages to the address listed below. (These may be submitted in batches, but must be submitted by the site point of contact.)

ProviderConnect

CBHNP

P. O. Box 6600

Harrisburg, PA 17112

3. FAXES ARE NOT PERMITTED
4. Documents submitted with white out will be returned to the Provider



CBHNP eCura® ProviderConnect Individual Registration

Agreement

I, _____, employed by _____
Provider Name

whose Federal Employer Identification Number (EIN) is _____ understand that all information on the Community Behavioral HealthCare Network of Pennsylvania’s database is confidential. I agree not to disclose any information regarding persons who have applied for, have received, who are receiving public assistance benefits, or behavioral health services, to any unauthorized persons.

I understand that I may only use the information in the performance of mandated activities of the Community Behavioral HealthCare Network of Pennsylvania, for which I have been authorized. I understand that the use or disclosure of any information concerning a recipient of assistance or service for any purpose other than the mandated activities of the Community Behavioral HealthCare Network of Pennsylvania is prohibited except on written consent of the applicant/recipient, his/her attorney, or his/her legally responsible relative.

I understand I may only use the Provider Connect web site for those specific functions for which I am authorized.

I understand my password is confidential and, as such, may not be written down. It is to be used only by me. Therefore, I agree to sign off whenever I leave my workstation. If I suspect that anyone else has knowledge of my password, I will immediately contact a Provider Connect representative.

By signing below, I am indicating that I have read this entire nondisclosure agreement and agree to abide by it. I also understand that any violation of this agreement may result in disciplinary action, which may include withdrawal of the right to use the database. Furthermore, I understand that criminal prosecution will be undertaken if I knowingly and intentionally disclose the information to anyone who is unauthorized, or use the data for fraudulent purposes.



Individual:

Provider's Site Point of Contact:

Signature

Signature

Print Name

Print Name

Title

Title

Date

Date

Office Phone: _____

Account Set Up

Individual will need the following access (please check all that apply):

- View Claims
- Enter Claims
- View Authorizations
- Enter Authorizations (not yet available)
- Add Provider Events
- View Provider Events
- Add Member Events
- View Member Events

Website Access Information

Desired User name: _____

Desired password (minimum 8 characters – maximum 14 characters): _____



*Note if username and password are blank, a username and password will be assigned to you.

**User name and password are not case sensitive.