



eCura® ProviderConnect Registration for Provider

**** Available to current in-network providers ****

- **ProviderConnect Registration for Provider is necessary to access the ProviderConnect features.**
- **ProviderConnect Registration is only required once.**
- **ProviderConnect Request for Individual Access may be submitted along with the ProviderConnect Registration for Provider.**

Instructions:

In order to complete provider registration for eCura® ProviderConnect, please do the following:

1. Complete the requested information.

Site Point of Contact and Trainer – 1 page

ProviderConnect® Participation Agreement – 2 pages

CONFIDENTIALITY STATEMENT – 2 pages

Please do not staple these documents prior to mailing.

2. Mail the above four 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



eCura® ProviderConnect Registration for Provider

Site Point of Contact and Trainer

Once ProviderConnect is in production, more and more providers will be using it. With this in mind we would like to keep this process as simple and consistent as possible. Therefore, we would like each Provider site to designate one point of contact person and one trainer.

The point of contact will be the person to contact us with any question or problems concerning ProviderConnect. He/She will also be the person CBHNP will contact with questions or if further information is needed. This person will also be responsible for sending all registration paper work to us and must ensure all necessary forms are signed and completed in full for each individual employee who will be accessing ProviderConnect.

The trainer will be the person CBHNP will train on how to access ProviderConnect. This person in turn is responsible for training everyone who will be using ProviderConnect at their Provider site.

Note: The point of contact and the trainer can be the same person. If this is the case please print "SAME" in the site trainer name line.

Site Point of Contact

Please list your site POC below.

Name: _____

Title: _____

Phone number: _____

*Email address: _____

* Mailing Address for Site Point of Contact

*Required

Site Trainer

Please list your site trainer below.

Name: _____

Title: _____

Phone number: _____

*Email address: _____



ProviderConnect® Participation Agreement

_____ (the Provider), whose Federal Employer Identification Number (EIN) is _____ and CBHNP intend to conduct certain transactions in electronic form through the use of ProviderConnect®. These transactions include but are not limited to: the submission of authorization requests; inquiries about the status of such requests; submission of claims; and inquiries about the status of claims submissions.

Both parties acknowledge and agree that the privacy and security of data held by or exchanged between them through ProviderConnect® is of utmost priority. Each party agrees to take all steps reasonably necessary to ensure that these transactions between them remain secure, and confidential in conformity with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated there under. Further, each party agrees that the submission of documentation and retrieval of information be conducted as specified below, and that all parties comply with the protocols and safeguards established for the responsible utilization of ProviderConnect®.

General Security Requirements

- (a) CBHNP agrees to construct a highly secure connection that is password protected for the benefit of the Provider and CBHNP.
- (b) Each party will take reasonable care to ensure that the information being exchanged is timely, complete, accurate and secure, and will take reasonable precautions to prevent unauthorized access to the control structure and equipment utilized in the exchange.
- (c) Each party is solely responsible for the preservation, privacy and security of data in its possession, including data in transmission received from the other party and other persons. If either party receives from the other data not intended for it, the receiving party will immediately notify the sender to arrange for its return, re-transmission, or destruction, as the other party directs.

Password Security Requirements

- (d) The provider agrees to apply strict protocols to the use of the password in order to access CBHNP information through ProviderConnect®.
- (e) Providers will only request access privileges only for personnel whose job functions and responsibilities require use of ProviderConnect®. Only those provider personnel identified and authorized by CBHNP may access ProviderConnect®.
- (f) Each password is for the use of a unique authorized individual. Sharing or disclosing a password to any other individual, including staff of the same provider, is strictly prohibited.
- (g) Provider will inform CBHNP immediately if a staff member is terminated, or has changed their position so that access is no longer necessary. CBHNP will immediately deactivate the password for such individuals.
- (h) The provider will notify CBHNP immediately if the confidentiality of the password is breached. CBHNP will deactivate the compromised password and make provisions for the selection of a new password.



Contact and Training Requirements

- (a) Provider will name one individual to be their contact person. CBHNP will communicate only with the contact individual with regard to policies, procedures, protocols and upgrades pertaining to the ProviderConnect® System.
- (b) Each provider may specify up to three individuals to serve as ProviderConnect® Trainers at the provider organization.
- (c) ProviderConnect® Trainers will be responsible for attending the complete course of instruction provided by CBHNP, and to demonstrate familiarity with the material presented.
- (d) The ProviderConnect® trainers will be responsible for training all provider staff for whom access to ProviderConnect® is requested. Training materials and instruction will be made available on the CBHNP website, and providers are responsible for making such documents available to identified staff.

IN WITNESS WHEREOF, CBHNP and provider have caused this Agreement to be signed and delivered by their duly authorized representatives as of the date set forth above.

On behalf of CBHNP

On behalf of Provider

Provider Name: _____

PROMISe ID/Service Location: _____

Print Name: _____

Print Name: _____

Signature: _____

Signature: _____

Executive Director (or designee)

Title: Vice President, Provider Network Operations

Title: _____

Date: _____

Date: _____



COMMUNITY BEHAVIORAL HEALTH NETWORK OF PENNSYLVANIA CONFIDENTIALITY STATEMENT

In the course of the relationship created between the Undersigned Party "Undersigned") and Community Behavioral Healthcare Network of Pennsylvania ("CBHNP"), the parties will have access to Confidential Information, which is defined in detail below. Confidential Information is protected by state and federal laws, including HIPAA and by CBHNP policies. The Undersigned agrees to abide by the terms of this Confidentiality Statement regarding such Confidential Information.

A. Confidential Information includes both "Protected Health Information" and "Proprietary Information." Protected Health Information means information about clients, such as past, present or future physical or mental health information, or personal or financial information, whether in written, verbal or electronic form. Proprietary Information means information related to the operations of CBHNP and/or its affiliates, including, but not limited to business and development documents; provider performance information; concepts and care management models; software in various stages of development; research; economic and financial analysis and records; trade secrets; human resources information (i.e., employment, promotion, salary and performance review); and miscellaneous copyrightable materials.

B. The Undersigned may access Confidential Information only as needed to perform legitimate duties pursuant to the relationship with CBHNP and/or its affiliates and agree not to disclose, communicate or use any Confidential Information, except as needed to perform such duties or as required by law.

C. Confidential Information may only be released to individuals outside of CBHNP and/or its affiliates upon written authorization from CBHNP.

D. The obligations contained herein will continue after termination of the relationship between the Undersigned and CBHNP.

E. Upon termination of the relationship between the Undersigned and CBHNP, the Undersigned shall delete all electronic material containing Confidential Information and shall return to CBHNP any and all hard copies of Confidential Information in the Undersigned's possession or control.

F. The Undersigned will be responsible for the misuse or wrongful disclosure of Confidential Information, and related penalties may include termination of the Undersigned's relationship with CBHNP and/or the commencement of legal proceedings.



I have read this Confidentiality Statement and understand it.

ORGANIZATION NAME (please print)

NAME (please print)

SIGNATURE

TITLE (please print)

DATE