

## IDENTIFICATION OF PROVIDER THIRD-PARTY REPRESENTATIVE

**Provider Organization Name:** \_\_\_\_\_

**Provider Organization TIN:** \_\_\_\_\_

Provider Organization (Provider) hereby authorizes the following ***third-party representative*** (i.e., billing agency, vendor, clearinghouse, application service provider) to represent the Provider in order to carry out administrative functions with Harvard Pilgrim Health Care that involve the use and disclosure of Protected Health Information (PHI) on behalf of the Provider:

Third Party Representative Information				Authorizations	
Third Party Company Name & Mailing Address	Contact Name & Title	Contact Phone Number	Contact eMail Address	EDI Solutions	HPHConnect Access
				Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

- “EDI Solutions” is performing any Electronic Data Interchange on behalf of the provider using standard EDI transactions, e.g., 837 claims submission, receive 835 remittance advice, 270/271 eligibility inquiry and response, 276/277 claims status inquiry and response, 278 referral/authorization/notification request or inquiry, etc.
- “HPHConnect Access” is access to any provider self-service function in this online application.
- Please note third-party access includes the authority of the third-party representative to manage access to your information for others within, or external to, their organization.

Provider hereby acknowledges that Harvard Pilgrim will only release to a third-party representative what could be released directly to the Provider per Harvard Pilgrim’s disclosure policy. Provider and its representative will adhere to all applicable HIPAA regulations, including the execution of Business Associate Agreements where applicable. Third-party representative will adhere to all applicable Harvard Pilgrim policies for EDI Solutions and/or HPHConnect Access as defined in the Harvard Pilgrim Provider Manual. The Provider hereby agrees to notify Harvard Pilgrim, immediately, in writing, if any of these designations change. Upon such notice to Harvard Pilgrim, third-party representative access will be terminated as of the date specified by the Provider.

<b>Third Party Access</b>	<b>Are you granting the third party representative access to your entire TIN?</b>	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Date</b>		
<b>Authorized Provider Organization Signature</b>		
<b>Print Name</b>		
<b>Title</b>		
<b>Phone</b>		
<b>Email Address</b>		
<b>Mailing Address</b>		

**Harvard Pilgrim cannot release or provide ANY Provider information to a Third-Party unless this form is completed.**

*Provider Organization Representative – please complete, sign, and return this form to:*

Fax to: 866-884-3844  
ATTN: Provider eBusiness Services

Email: [provider\\_ebusiness\\_services@point32health.org](mailto:provider_ebusiness_services@point32health.org)

