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☐ N☐	**Y☐ N☐**

- "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.

Third Party Access	**Are you granting the third party representative access to your entire TIN?**	**Y☐ N☐**
Date		
Authorized Provider Organization Signature		
Print Name		
Title		
Phone		
Email Address		
Mailing Address		

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

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

ATTN: Provider eBusiness Services
Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169-0913

OR

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

Email: provider_ebusiness_services@hphc.org

Harvard Pilgrim Health Care