



## Driscoll Children's Health Plan Web Portal Agreement

I, the undersigned, request access to the Driscoll Children's Health Plan (DCHP) web portal on behalf of the provider office or facility shown below for the purposes of: (1) verifying DCHP member eligibility, (2) verifying the status of claims submitted to DCHP, and (3) other functionalities that may be provided in the future.

As part of this access, I acknowledge and agree to the following terms and conditions:

- (1) To assign a portal administrator to be responsible for adding, changing, and terminating portal access as staff turn-over occurs for the staff and employees of this organization.
- (2) To ensure that terminated or resigning staff or employees shall have their access to the portal deactivated concurrent with their departure from our organization.
- (3) To ensure with all reasonable and effective efforts that the information contained in the portal will be treated as confidential and used solely for purposes authorized by applicable laws, rules and regulations, including, but not limited, the Health Insurance Portability and Accountability Act with regard to Personal Health Information.
- (4) To notify the Provider Relations Department immediately of a change in this organization's assigned portal administrator.
- (5) Subsequent to initial set-up and training of applicable staff by DCHP, to ensure that new or additional staff or employees given access to the portal by this organization are trained on how to use the portal using training materials provided by DCHP.

Signed by: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Signer: \_\_\_\_\_

Practice or Facility Name: \_\_\_\_\_

Portal Administrator: \_\_\_\_\_

e-Mail Address of Portal Administrator: \_\_\_\_\_

Telephone Number of Portal Administrator: \_\_\_\_\_

TAX ID: \_\_\_\_\_



**Driscoll Children's Health Plan  
Web Portal Sign up Information Form**

To assure correct set up and easy access to the Web Portal please provide Driscoll Children's Health Plan with the information below and return with your signed Web Portal Agreement.

**Practice Name:**

**Address:**

**Phone #:**

**Fax#:**

**Primary Contact Name:**

**Email Address:**

**Tax ID**

**Provider name (s):**

*(Please Print Clearly)*

**Employee Name:**

**Email address:**

**Please select employee role: Back Office \_\_\_\_\_ Front Desk \_\_\_\_\_ Super User \_\_\_\_\_**

*Employee Name:*

**Email address:**

**Please select employee role: Back Office \_\_\_\_\_ Front Desk \_\_\_\_\_ Super User \_\_\_\_\_**

**Employee Name:**

**Email address:**

**Please select employee role: Back Office \_\_\_\_\_ Front Desk \_\_\_\_\_ Super User \_\_\_\_\_**

**Employee Name:**

**Email address:**

**Please select employee role: Back Office \_\_\_\_\_ Front Desk \_\_\_\_\_ Super User \_\_\_\_\_**

**Employee Name:**

**Email address:**

**Please select employee role: Back Office \_\_\_\_\_ Front Desk \_\_\_\_\_ Super User \_\_\_\_\_**

**FAX COMPLETED FORM TO 361-653-7850**