Application / Agreement for Web Portal Use

(A separate application / agreement must be completed for each independent PCP)

I (We) hereby request authorization from MHM Health, LLC. to use the web based management system for the following:

( ) Eligibility Verification
( ) Claims / Encounters Submission
( ) Claims Status
( ) Authorization Requests
( ) Authorization Status

I agree to employ reasonable security procedures to ensure the privacy, security and integrity of data electronically exchanged.

I hereby agree that the information submitted via the web portal is accurate, reliable and complete.

I agree to adhere to the HIPAA policies and procedures regarding patient privacy and the security of patient privacy and the security of patient information.

I have read the above agreement and agree to comply with its terms as condition of access to the web portal.

PCP Name (Printed)	Signature	Date

PCP Office Information:

Primary Provider Name:_____

Telephone:_____

Contact Email: _____

*A Valid E-mail and Telephone are Required to use web application

Please supply MHM Health with your Staff Name:	User type (Circle One)	
Staff Name:_____	Claims	Authorizations
Staff Name:_____	Claims	Authorizations
Staff Name:_____	Claims	Authorizations
Staff Name:_____	Claims	Authorizations

Once the information from your office has been verified, we will E-mail you a unique password and link to the web site. We will not send the user name for security purposes in this e-mail.

This authorization is to remain in full force and effect until Provider received written or verbal notification from MHM Health of its termination in such time and in such manner as to afford Provider opportunity to act on it.

Please supply a list of additional Physicians associated with your Office or Billing Office with each Provider signing their initials next to their name:

Provider Name: _____ Signature: _____

Provider Name: _____ Signature: _____

Provider Name: _____ Signature: _____

Provider Name: _____ Signature: _____

Provider Name: _____ Signature: _____

Provider Name: _____ Signature: _____

Please supply the following requested information:

(Main contact person can be a PCP, Office Manager, Administrator or Supervisor

**Main Contact Name: _____

**Contact Phone: _____

**Contact Fax: _____

**Contact E-mail: _____

** All E-mail Addresses and Telephone Numbers will be verified to use web application.
All information for verification and password or password re-setting will be sent to Contact.

Fax Application to (909) 947-8708

Or Mail to:
MHM Health LLC.
Attn: Remote Access
310 VanderBilt Way, San Bernardio, CA
92408

Internal Use Only

All Providers Verified by: _____Date:_____
Provider E-Mail Address Verified by: _____Date: _____
Provider Phone # Verified by: _____Date: _____
Contact E-Mail Address Verified by: _____Date: _____
Contact Phone # Verified by: _____ Date: _____

E-Mail Password and Link by: _____ Date: _____