



Tufts Health Provider Connect Authorization Form

Instructions for completing web access registration:

For each Organization

- Complete online registration at tuftshealthplan.com/providerconnect.
- Complete one Authorization Form.
- Insert organization name and the corresponding TIN(s) in the boxes provided below.
- Please fax your completed form to 857.304.6150 or mail your form to the following address:

Tufts Health Plan
 Attn: EDI Portal Website Specialist
 P.O. Box 9194
 Watertown, MA 02471-9194

*[Organization Name]	*[TIN]
[TIN]	[TIN]

*Will account users need access to all TIN lists on this agreement?

- Yes, all account users will need access to all listed TINs
 No, each user will need access to a specific TIN or combination of TINs

The above named organization (“Provider”) hereby authorizes and requests that Tufts Health Public Plans, Inc. (“Tufts Health Plan”) provide, to the Administrator designated below, electronic access to information submitted by the Provider related to health care services provided to Members. Provider may choose to designate himself/herself as Administrator. If Provider chooses to delegate the Administrator role, that person will be permitted to perform certain functions pertaining to Provider on the Tufts Health Plan website, including but not limited to accessing claims information, submitting referrals, and pre-registering admissions on Provider’s behalf. Provider understands that Administrator will also be responsible for granting and terminating additional access to Provider’s website account to Administrators and Authorized Users and also reconciling terminated users on a regular basis. Pursuant to this Authorization Form, Tufts Health Plan will grant access to Administrator and to any Administrators and/or Authorized Users designated by Administrator. Tufts Health Plan will also grant access to any Authorized Users designated by Administrator.

Provider understands that as the provider of health care services Provider is responsible for compliance with all applicable federal and state requirements concerning the confidentiality of health care information, and that Provider retains ultimate responsibility for the actions and use of that information by those designated pursuant to this Authorization Form. Provider understands that Tufts Health Plan will require that any person Provider designates as an Administrator, as well as any Access Administrators and/or Authorized Users, must accept certain Terms of Use agreeing to comply with, among other things, HIPAA and other state and federal requirements concerning the confidentiality and security of protected health information. Provider further understands that it is Provider’s responsibility to inform Tufts Health Plan of any changes to this Authorization Form and that Tufts Health Plan or Provider can terminate this Authorization Form at any time.

I have read, understand, agree to, and accept the terms of this Authorization Form and I hereby grant the above authority and responsibility to the Administrator designated below:

Authorization Form signature requirements:

For the purposes of website registration and signature requirements for this Authorization Form, the individual executing this Authorization Form must be the “Officer” of the Provider. An “Officer” is defined as an individual empowered by that entity to bind the organization in this legal agreement.

Officer (*required fields)	Administrator
_____	I choose to delegate the administration of my Tufts Health Plan website account to:
*Print Name	
_____	Same as Provider or Officer
*Print Title	Another Individual (complete fields below)
_____	_____
*Email Address	*Print First Name
_____	_____
*Phone	*Print Last Name
_____	_____
*Signature	*Phone Number
_____	_____
Date	*Email Address
_____	Administrator
Print Name of Provider	I choose to delegate the administration of my Tufts Health Plan website account to:
	Same as Provider or Officer
	Another Individual (complete fields below)

	Print First Name

	Print Last Name

	Phone Number

	Email Address

	Administrator
	I choose to delegate the administration of my Tufts Health Plan website account to:
	Same as Provider or Officer
	Another Individual (complete fields below)

	Print First Name

	Print Last Name

	Phone Number

	Email Address
