Provider Performance Assessment (PPA) Portal User Agreement and Login Request

Please complete form **(print clearly)** and email to: Healthy Connections at ProviderPortal@dhw.idaho.gov or fax to: 1-888-532-0014

Healthy Connections (HC) Organization Information: (as appears in Molina Medicaid system)

HC Organization Name: _____

HC Organization Tax ID #: _____

HC Service Location Name: _____
***To request access to additional HC Service Locations within the same Organization, please complete the section at the end of this form*

HC Service Location Street Address: _____

City: _____ State: _____ Zip Code: _____

NEW USER INFORMATION:

First Name: _____ Middle Initial: _____

Last Name: _____Title: _____

Phone/Extension: _____E-Mail (required): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____
**This address will be used by Watson Health to send a "hard token" to each user. The token is a two-factor authentication security device that is required for each user to access the portal.*

Job Category: __ HC Provider __Administration __PCMH Lead __Care Coordinator/Care Manager
__Data Analyst __Other (list): _____

SECURITY ADMINISTRATOR INFORMATION:

First Name: _____ Middle Initial: _____

Last Name: _____Title: _____

Phone Number: _____E-Mail (required): _____
**Each Organization is required to designate a Security Administrator (SA) who will be responsible for authorizing portal users.*

HIPAA Notice

This Watson Health Provider Performance Assessment Portal is for the use of authorized users only. Users of this portal may have access to protected, personally identifiable health data. As such, this portal and its data are subject to the Privacy and Security Regulations within the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA). By accessing this portal, all users agree to protect the privacy and security of the data contained within as required by law. Access to information on this site is only allowed for necessary business reasons and is restricted to those persons with a valid user name and password.

ATTESTATION TO THE IDAHO DEPARTMENT OF HEALTH AND WELFARE PRIVACY AND SECURITY POLICIES AS STATED IN THE IDAHO MEDICAID PROVIDER AGREEMENT. Each User must attest to the following as indicated by his/her signature below:

To comply with the Health Insurance Portability and Accountability Act (HIPAA), §§ 262 and 264 of Public Law 104-191, 42 USC § 1320d, and federal regulations at 45 CFR Parts 160 and 164. The Provider shall comply with all amendments of HIPAA and federal regulations made during the term of the Contract. The Provider specifically acknowledges its obligation to comply with 45 CFR Section 164.506, regarding use and disclosure of information to carry out treatment, payment or health care operations.

To protect the confidentiality of identifying participant information that is collected, used, or maintained according to IDAPA 16.05.01, "Use and Disclosure of Department Records."

Upon receipt of this completed request, you will be sent a hard token and e-mail from Watson Health with instructions on how to access the portal.

I agree to abide by the laws governing security of PHI and the policies of the Idaho Department of Health and Welfare (IDHW) Medicaid Provider Agreement. I will not share my username, password or hard token with anyone. I understand my PPA Portal Access will be terminated for users demonstrating no activity for a period of six months and reapplication will be required.

User Printed Name: _____

User Signature: _____ Date: _____

Security Administrator Printed Name: _____

Security Administrator Signature: _____ Date: _____

ADDITIONAL SERVICE LOCATION REQUESTS

HC User Name (Last, First, Middle initial): _____

HC Service Location Name: _____

HC Service Location Street Address: _____

City: _____ State: _____ Zip Code: _____

HC Service Location Name: _____

HC Service Location Street Address: _____

City: _____ State: _____ Zip Code: _____

HC Service Location Name: _____

HC Service Location Street Address: _____

City: _____ State: _____ Zip Code: _____

HC Service Location Name: _____

HC Service Location Street Address: _____

City: _____ State: _____ Zip Code: _____

HC Service Location Name: _____

HC Service Location Street Address: _____

City: _____ State: _____ Zip Code: _____

HC Service Location Name: _____

HC Service Location Street Address: _____

City: _____ State: _____ Zip Code: _____