Non-Physician Website Access Request Form

OHIOHEALTH
Clinically Integrated
NETWORK

SECTION A: GENERAL WEBSITE ACCESS

Please complete the fields below to obtain access to the members-only side ("My Dashboard") of the OhioHealth Clinically Integrated Network's (CIN) website – www.OhioHealthGroupCIN.com. If you have questions while completing the form, please contact the Provider Service Center at 614-566-0003 or 877-644-7469 (toll free).

Please Note: Information provided **MUST** be unique to the individual, including email addresses. The email address you submit will be your website username and will be used for all OhioHealth and OhioHealth CIN communications.

APPLICANT INFORMATION					
Last Name:		**First:**		**M.I.:**	
Practice Job Title:			**DOB:**	___ /___ /_____	
Email Address:					
Primary Phone Number:					

PRACTICE INFORMATION					
Practice Tax Payer Identification Number (TIN):	___ ___ ___ ___ ___ ___ ___ ___ ___				
Practice Name:					
Practice Street Address:					
Suite / Floor:		**City:**		**ZIP:**	

WEBSITE ROLE

The website role you select helps us ensure that you receive relevant communications and have access to sections of the website most applicable to your position in your practice. Please review the options on the next page, and **select the ONE role that most closely resembles the role you have in your practice.** An OhioHealth CIN participating physician in your practice must sign this form to authorize your role (Section D). Your website role and permissions can be modified if your position changes.

Please Note: Fee Schedules and Physician Support Tool access must be requested in Section B and Section C of this form.

WEBSITE ROLE (PLEASE CHECK ONE)

- ☐ **Office Manager:** This role has access to view and manage participation requirements for physicians in the practice, can view CIN contract administrative rules, quality program detail reports, clinical guidelines and metrics, educational materials and register for events. All communications relevant to office managers will be sent to users with this role.

- ☐ **Billing Manager:** This role has access to view CIN contract administrative rules, clinical guidelines and metrics, register for events and view educational material. All communications relevant to Billing Managers will be sent to users with this role.

- ☐ **Advanced Practice Provider (APP):** This role has access to view clinical guidelines and metrics, educational materials and can register for events. All communications relevant to Advanced Practice Providers/non-physician clinical staff will be sent to users with this role.

- ☐ **Office Staff:** This role has access to view clinical guidelines and metrics, educational materials and can register for events. All communications relevant to general office staff, including billing staff, will be sent to users with this role.

- ☐ **Practice Executive:** This role has access to view CIN contract administrative rules, clinical guidelines and metrics, and the ability to register for events and view educational material. All communications relevant to practice executives will be sent to users with this role.

SECTION B: FEE SCHEDULE ACCESS

Do you need access to your practice's CIN Fee Schedules? ☐ **YES** ☐ **NO**

If yes, please review/sign the disclaimer below. An OhioHealth CIN participating physician in your practice must sign this form to authorize this request (Section D).

APPLICANT DISCLAIMER AND SIGNATURE

I understand that the financial terms of all OhioHealth Clinically Integrated Network (CIN) contracts are strictly confidential. I agree not to communicate financial information about OhioHealth CIN contracts to anyone other than my practice's office staff and professional advisors. I understand that I am not authorized to share OhioHealth CIN fee schedule information, and that **any dissemination of OhioHealth CIN fee schedule information to third parties may be a violation of the applicable federal and state antitrust laws**. I agree to keep any and all fee schedule information shared with me confidential, whether verbal, electronic or written. I recognize that disclosure of or sharing of login/ access codes and passwords assigned to me is prohibited and that
I am accountable for them and any improper access to information gained with these privileges. My access privileges are the equivalent to my legal signature and I shall take all reasonable and necessary steps to protect my access privileges. I acknowledge that I am responsible for all actions taken using those privileges. If I have reason to believe that the confidentiality of my access privileges have been broken, I shall immediately notify the Provider Service Center at 614-566-0003 or 877-644-7469 (toll free).

Signature:		**Date:**	___ /___ /_____

If you have fee schedule responsibilities for **more than one OhioHealth CIN practice,** please contact the Provider Service Center at 614-566-0003 or 877-644-7469 (toll free).

SECTION C: PHYSICIAN SUPPORT TOOL ACCESS

Do you need access to the Physician Support Tool? ☐ **YES** ☐ **NO**

If yes, please complete the fields below and review/sign the disclaimer below. An OhioHealth CIN participating physician in your practice *who has applicable Quality Program measures* must sign this form to authorize this request (Section D). Once authorized, you must view a HIPAA Data Privacy and Security video before you can access the Physician Support Tool.

Social Security Number:	____ ____ ____ - ____ ____ - ____ ____ ____ ____
This information is collected to protect you, your patients and your practice. Because of Patient Health Information (PHI) in the Physician Support Tool, we need to be able to verify the identity of users.	

APPLICANT DISCLAIMER AND SIGNATURE			
I agree to keep any and all protected health information that is shared with me, whether verbal, electronic or written through the OhioHealth Clinically Integrated Network's (CIN) Physician Support Tool, confidential. I agree to keep the OhioHealth CIN protected health information private and secured at all times in accordance with the laws of the State of Ohio, HIPAA & the HITECH Act. I understand the information made available to me is only on a need-to-know basis and that I will not access confidential information without authorization and will do so only when required to do so. I recognize that the unauthorized disclosure of confidential information is prohibited. I recognize that the disclosure of or sharing of login/access codes and passwords assigned to me is prohibited and that I am accountable for them and for any improper access to information gained with these privileges. My access privileges are the equivalent to my legal signature and I shall take all reasonable and necessary steps to protect my access privileges. I acknowledge that I am responsible for all actions taken using those privileges. If I have reason to believe that the confidentiality of my access privileges has been broken, I shall immediately notify the Provider Service Center at 614-566-0003 or 877-644-7469 (toll free).			
Signature:		**Date:**	___ /___ /_____

If you have Physician Support Tool responsibilities for **more than one OhioHealth CIN practice or location,** please contact the contact the Provider Service Center at 614-566-0003 or 877-644-7469 (toll free).

PLEASE CONTINUE TO SECTION D ON THE FOLLOWING PAGE

SECTION D: AUTHORIZING PHYSICIAN(S)

To complete this request form, an OhioHealth CIN participating physician(s) must authorize your website role and any additional access (Fee Schedules and/or the Physician Support Tool) by completing the fields and signing the disclaimer below.

AUTHORIZING PHYSICIAN INFORMATION					
Last Name:		**First:**		**M.I.:**	
Primary Phone Number:		**DOB:**	___ /___ /_____		
Email Address:					

AUTHORIZING PHYSICIAN DISCLAIMER AND SIGNATURE			
I authorize the applicant named on this request form to have access to the following (please check all that apply based on the completed sections above): ☐ "My Dashboard," the members-only side of www.OhioHealthGroupCIN.com ☐ OhioHealth CIN Fee Schedules ☐ OhioHealth CIN Physician Support Tool (and thereby the practices' patient information) I certify that the applicant will be bound to HIPAA, HITECH and any and all laws of the State of Ohio related to antitrust, data security and privacy. I will notify the Provider Service Center at 614-566-0003 or 877-644-7469 (toll free) when the staff member's access needs to be terminated.			
Signature:		**Date:**	___ /___ /_____

FOR OHIOHEALTH CIN INTERNAL USE ONLY			
Application is: Approved ☐ Denied ☐	**CIN / PSC Processor Notes:**		
CIN Processor Name:		**Process Date:**	
PSC Processor Name:		**Process Date:**	

PLEASE FAX (614-566-0433) OR EMAIL (TBlackmon@OhioHealthGroup.com) THIS FORM TO THE CIN PROVIDER NETWORK COORDINATOR