PHP | PROVIDER WEBSITE USER SET-UP

PHYSICIANS HEALTH PLAN OF NORTHERN INDIANA (ONLY)

Please complete this form to allow access to secure information on the Provider Portal at phpni.com. A separate form must be completed for each representative for which you are requesting access. This form must be submitted at least 10 business days prior to when the user needs access to the site.

Please email completed forms to providercontracting@phpni.com. For questions please contact Hannah at 260-432-6690 or 800-982-6257, ext 479.

PROVIDER SETUP INFORMATION

Provider name _____

Group name _____

Tax ID # _____

User last name _____

User first name _____

User email address _____

User phone number _____

By signing below, I agree and acknowledge: 1) to maintain the confidentiality of all information provided via PHP's website in compliance with all applicable laws and PHP's policies; 2) to not allow any other person to learn or use my password; 3) to notify PHP in the event I have reason to believe somebody has my password or has attempted to access the PHP website in my name; 4) to not attempt to alter any information on the website; 5) to notify PHP within 24 hours of my separation from the provider identified above; 6) that PHP reserves the right to limit, suspend or terminate my access to the website; and 7) that my employer and I will hold PHP harmless in the event I breach any of the above terms.

_____ _____

SIGNATURE DATE

FOR OFFICE USE ONLY

User name: _____

Password: _____

Date password was sent: _____

Who sent password: _____

Employer Group: _____YES _____NO