



## Employer Tools Enrollment Form

If you are an employer that offers Fallon Community Health Plan and you would like secure access to Employer Tools on fchp.org, please fill out the form below. Upon receipt and review by FCHP, the name of the directory where files can be dropped off and picked up, as well as your username and password, will be forwarded to the authorized individual listed as the contact. If you do not hear back from us within 15 business days, please call 1-800-333-2535, ext. 69968, to confirm receipt.

Employer information		
Employer name:	Employer Identification Number (EIN):	
Employer street address (line 1):		
Employer street address (line 2):		
City:	State:	ZIP:
Telephone number:	Fax number:	
Employer contact name/title/phone number:	Employer contact e-mail address:	
IT contact name/title/phone number:	IT contact e-mail address:	

Employer Tools user authorization					
I authorize the following employees' access to Employer Tools and electronic data submission through fchp.org, as indicated. For third party agencies to have access to Employer Tools, please complete the Billing Agency/Broker Authorization Form in addition to this form.					
Employee name	Employee e-mail address	Keyword hint for forgotten password	Employer Tools		
			Drop off eligibility file	Pick up electronic reports	Online enrollment
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Electronic data submission method (Complete only if you checked "Drop off eligibility file" or "Pick up electronic reports" above.)	
Check which of the following method(s) you would prefer to use for file submission.	
<input type="checkbox"/> <b>VPN client connectivity</b> - This option is best for trading partners who will be submitting and retrieving their files from one PC. Requires Windows 95/98/ME/2000 SP 2 or higher/Windows XP SP 1 or higher and an Internet connection.	
<input type="checkbox"/> <b>LAN-LAN VPN connectivity</b> - This option is best for trading partners who submit large electronic files or submit electronic files on a regular basis. Requires employer to have their own VPN appliance compatible with Cisco concentrators and to be able to support 3DES, ESP, MD5, Pre-Shared Key. This function extends your current network, resulting in seamless file transfers to FCHP, and there is no client software to install.	
<input type="checkbox"/> <b>Secure file transfer using the Web</b> - Browser must support SSL and be able to handle 128-bit encryption. We require using IE 5.0 or greater or Netscape 6.0 or greater. FCHP file transfer will transfer files to and from FCHP via HTTPS. It is recommended for transferring files of 10 Mb or less.	
What is the average size of your files?	
How often will files be dropped off and picked up? <span style="margin-left: 100px;"><input type="checkbox"/> Daily</span> <span style="margin-left: 50px;"><input type="checkbox"/> Weekly</span> <span style="margin-left: 50px;"><input type="checkbox"/> Monthly</span>	
How many files will be dropped off or picked up?	

Naming convention
The following naming convention is required for electronic eligibility files: XXMMDDV1.834 (eight characters) {letters to identify trading partner name/month/day/version number}
<b>Note: If it is necessary to resubmit a file, please put an "R" in front of the standard naming convention. For example, RXXMMDDV1.834 (Maximum of eight characters following the "R.")</b>

## Employer Tools Enrollment Form (continued)

### Agreement terms

I will protect all usernames and passwords given to me during this registration process from unauthorized use and disclosure. I understand that I am responsible for all actions performed while accessing Employer Tools. I will notify Fallon Community Health Plan (FCHP) immediately by calling FCHP at 1-800-333-2535, ext. 69968, if I believe a password has been compromised. I will notify FCHP to disable access when an employee's responsibilities no longer require using Employer Tools, or when an employee terminates.

I understand that as an employer, I am responsible for compliance with all federal and state requirements regarding the confidentiality of health care information and that I have responsibility for the actions and use of that information for those users I have designated access. The undersigned agrees to indemnify and hold harmless FCHP for any breach of this confidentiality agreement and shall be liable to FCHP for any such breach of this agreement and damages resulting from such breach, including but not limited to, interference and contractual relations, interference with advantageous relations, loss of any contract and any other losses and/or damages together with FCHP's expenses in connection with the breach, including but not limited to costs, accountant fees, consultant fees and reasonable attorney's fees.

I authorize FCHP to receive and process eligibility electronically in accordance with applicable regulations. I assure that all information submitted is accurate and any eligibility submitted in falsification are prosecutable under state and/or federal laws.

All information provided on the FCHP Web site is accurate to the best of our knowledge. FCHP shall not be liable for any claims, loss or damage resulting from its use.

### Signatures

Legal name of employer organization (please print):

Individual signing for employer organization/title (please print):

Individual's authorizing signature:

Date:

### Mail completed request form to:

Fallon Community Health Plan  
Attention: EDI Coordinator  
10 Chestnut St.  
Worcester, MA 01608-2810



## Billing Agency/Broker Authorization Form

To grant secure access to a third party billing agency or broker to Fallon Community Health Plan's Employer Tools on fchp.org, please fill out the form below. Upon receipt and review by FCHP your assigned username and password will be forwarded to each authorized individual. If you do not hear back from us within 15 business days, please call 1-800-333-2535, ext. 69968, to confirm receipt.

<b>Billing agency/broker information</b>		
Billing agency/broker name:	EIN of employer being represented:	
Street address (line 1):		
Street address (line 2):		
City:	State:	ZIP:
Telephone number:	Fax number:	
Contact name/title:	Contact e-mail address:	

<b>Agreement terms</b>
<p>The undersigned employer authorizes the above-named billing agency/broker access to Employer Tools on fchp.org to submit data to FCHP on the employer's behalf. As such, the employer accepts full liability for all actions of the above-named billing agency/broker and is responsible for any violations of laws and regulations.</p> <p>I will protect all usernames and passwords given to me during this registration process from unauthorized use and disclosure. I understand that I am responsible for all actions performed while accessing Employer Tools. I will notify FCHP immediately by calling 1-800-333-2535, ext. 69968, if I believe a password has been compromised. I will notify FCHP to disable access when an employee's responsibilities no longer require using Employer Tools or when an employee terminates.</p> <p>I understand that as the employer, I am responsible for compliance with all federal and state requirements regarding the confidentiality of health care information, and that I have responsibility for the actions and use of that information for those users I have designated access. The undersigned agrees to indemnify and hold harmless FCHP for any breach of this confidentiality agreement, and shall be liable to FCHP for any such breach of this agreement and damages resulting from such breach, including but not limited to interference and contractual relations, interference with advantageous relations, loss of any contract and any other losses and/or damages together with FCHP's expenses in connection with the breach, including but not limited to costs, accountant fees, consultant fees and reasonable attorney's fees.</p> <p>I authorize FCHP to receive and process eligibility electronically in accordance with applicable regulations. I assure that all information submitted is accurate and any claims submitted in falsification are prosecutable under state and/or federal laws.</p> <p>All information provided on the FCHP site is accurate to the best of our knowledge. FCHP shall not be liable for any claims, loss or damage resulting from its use.</p>

<b>Signatures</b>		
Legal name of employer organization (please print):		
Individual signing for employer organization/title (please print):	Individual's authorizing signature:	Date:
Billing agency/broker name/title (please print):	Billing agency/broker signature:	Date:

**Mail completed request form to:**  
 Fallon Community Health Plan  
 Attention: EDI Coordinator  
 10 Chestnut St.  
 Worcester, MA 01608-2810