ProAuth enrollment form

As a Fallon Health provider, if you would like secure access to the ProAuth tool, please have your office manager complete all fields in this form and send it to askfchp@fallonhealth.org. When Fallon receives and reviews this form, your assigned username and password will be forwarded to each authorized individual in your office and/or practice. Please note, the set up process can take up to 21 business days. Should you need to access any other Fallon Health provider tools, please sign up separately online at fallonhealth.org or contact your Provider Relations Representative.

Provider office information		
Contact name (Person completing this form)		Today's date (MM/DD/YYYY)
Practice phone number	Practice email address	
Provider/facility name		
Group NPI number		
Practice street or mailing address		
City	State	ZIP

Providers to be included If you have more than eight (8) providers, please supply your group NPI number only. We will contact you.	
Physician name	Individual NPI number
Physician name	Individual NPI number
Physician name	Individual NPI number
Physician name	Individual NPI number
Physician name	Individual NPI number
Physician name	Individual NPI number
Physician name	Individual NPI number
Physician name	Individual NPI number
Physician name	Individual NPI number
Employees to have access to the ProAuth tool	
Employee name	Employee email address
Employee name	Employee email address
Employee name	Employee email address
Employee name	Employee email address
Employee name	Employee email address
Employee name	Employee email address

Employee name	Employee email address
Employee name	Employee email address

See reverse for agreement terms and authorized names and signatures

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 ProAuth. I will notify Fallon Health immediately by calling 1-866-275-3247,option 6, if I believe a password has been compromised. I will notify Fallon Health to disable access when an employee's responsibilities no longer require using this tool, or when an employee terminates.

I understand that as the provider of health care services or trading partner or delegate, 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 for whom I have designated access. The undersigned agrees to indemnify and hold harmless Fallon Health for any breach of this confidentiality agreement, and shall be liable to Fallon Health 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 Fallon Health's expenses in connection with the breach, including, but not limited to, costs, accountant fees, consultant fees and reasonable attorney's fees.

I authorize Fallon Health to receive and process electronic date transactions 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.

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

Signatures	
Legal name of physician group:	
Individual authorized to sign for organization/title:	
Individual's authorizing signature:	Today's date (MM/DD/YYYY)