IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

Provider Web Portal Application

Provider Information

First Name	Last Name	Group / Organization	
Email Address	Tax ID	National Provider Identifier (NPI)	License
Provider Type ☐ Primary Care ☐ Specialist ☐ Ancillary			

Location Information

Street Address			Suite	Phone Number
City	State	Zip		Fax Number

Staff User Information

First Name	Last Name	Title
Email Address	Phone Number (If different)	

By signing below:

A.) I agree to adhere to HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations promulgated and ensure that equipment, software and devices utilized by me or my delegated Business Associate be safeguarded and secure against unauthorized use or access;

B.) I agree to ensure that equipment, software and devices utilized be assessed periodically to mitigate possible breaches of security, up to and including, utilization of virus scans and protective firewalls;

C.) I agree to ensure my staff and/or delegated business associate assigned to conduct any data interchange has executed a confidentiality agreement and has received appropriate training to safeguard elements of HIPAA, up to and including, the safeguarding of passwords;

D.) I hereby agree that the information submitted to Imperial Health Plan is accurate, reliable and complete;

E.) I understand that it is my responsibility to notify Imperial Health Plan when a staff user login needs to be deactivated, at which point, an amended application will be required for new access;

F.) I understand that any breach to the provisions of this agreement that is not curable within thirty (30) days of notification by Imperial Health Plan to me shall null and void this agreement, and Imperial Health Plan shall immediately rescind and terminate electronic utilization and access;

G.) I understand that Imperial Health Plan has the right to deny or deactivate my access at any time.

Authorized Staff/Provider Name (Print) _____ Title _____

Signature _____ Date _____

INTERNAL USE ONLY			
Representative	Date	Decision ☐ Approved ☐ Denied	
Provider Username	Password	Staff Username	Password

Please fax completed forms to (626) 380-9142