KOVAHealthcare, Inc.
Doctor focused patient centered.
7061 N. WHITNEY SUITE 102 FRESNO, CA 93720

Provider Web Portal Application

Provider Information

First Name	Last Name	National Provider Identifier (NPI)	License
Group / Organization Name	Tax ID	Group/Billing NPI	
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 KOVAHealthcare Plan is accurate, reliable and complete;
E.) I understand that it is my responsibility to notify KOVAHealthcare 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 KOVAHealthcare Plan to me shall null and void this agreement, and KOVAHealthcare Plan shall immediately rescind and terminate electronic utilization and access;
G.) I understand that KOVAHealthcare 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