Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

CLAIMS - CARE MANAGEMENT INTEGRATION SECURE FILE TRANSFER PROTOCOL (SFTP) ACCESS FORM

Please fill out the entire form and return it to the IT Department at Trillium Health Resources using PDSupport@TrilliumNC.org or fax to 1-252-215-6874. Please allow 7-10 working days for the SFTP user account to be set up.

NOTE: There is only 1 set of login accounts per agency for Inbound & Outbound.

SFTP ALLOWS ACCESS TO ALL FILES IN THE AGENCY FOLDER USING YOUR SINGLE AGENCY LOGIN

Agency Name: _____ **Provider Direct ID#** _____

Agency Requester Contact Name: _____ Title: _____

Agency Requester Contact Email: _____ **Phone:** _____

Is this the first request for SFTP access for your organization? Yes ☐ No ☐

Are you the Provider Direct system administrator for your organization? Yes ☐ No ☐

Are you a Tailored Care Management (TCM) Agency? Yes ☐ No ☐

- If yes, the question below is required. If no, skip the next question.

Will you be using a Clinically Integrated Network (CIN)? Yes ☐ No ☐

- If yes, a CIN or Data Partner contact is required below in addition to the CINcontact signature.

Please provide the information below for the staff, faculty, and/or employees for whom the Agency is requesting Authorization to have SFTP access. Access will be through the Agency's single access login. If more than 2 Users are named, please attach an additional form with all requested information. If the Agency is requesting access for a third-party vendor, the Agency shall indicate the third-party vendor's company name in the Contact Name field, in addition to the email address and access request type.

Contact Name	Email Address	+Add	-Rem	Change

Terms and Conditions: **Next page**

Terms and Conditions

By signing below, the Requester is verifying that Requestor is authorized to sign this Form on behalf of

Agency and Requestor is authorized to bind Agency to the terms and conditions set forth herein. Agency shall ensure that access to SFTP is limited to those Contact Names identified above and shall not grant SFTP access to any other Contact Names without prior request and authorization from Trillium Health Resources. Agency shall not provide Agency's login information to any individual or entity not identified above or in any way permit, authorize, or allow any individual or entity not identified above access to SFTP files.

Agency shall keep all information retrieved from SFTP secure, including but not limited to taking all actions necessary to comply with all applicable federal, state, and local laws and regulations concerning the privacy and confidentiality of Protected Health Information ("PHI"), as defined in 45 C.F.R. 160.103, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996

("HIPAA"), the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, subparts A and E, the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, subpart C and any other law or regulation that refers or relates in any manner to the privacy and confidentiality of PH.

Agency shall not upload files that are not requested by Trillium Health Resources personnel. Agency acknowledges that if it or any Contact Name above abuses access to SFTP or in any manner compromises the security of SFTP, Agency's access shall be terminated without prior notification. Trillium Health Resources reserves the right to terminate Agency's access to SFTP at any time for any reason.

******PLEASE NOTE: Documents in this folder will be subject to deletion after 90 days!***

By signing below, Agency authorizes the Contact Names for SFTP access consistent with the intent of the Terms and Conditions above.

Agency understands that Contact Names will have access to ALL Agency files and that file level restrictions cannot be imposed by Trillium Health Resources. Agency has verified that the Contact Names understand and accept their responsibilities for security of data received using this account and agree to comply with the Terms and Conditions above.

Agency Requester Signature: _____ Requester Title: _____

Agency Requester Name: (Print): _____ Date: _____

TCM CIN Contact Signature: _____ Date: _____

For IT Department Use Only					
Provider is Active/Available/Form Information matches TBS:				Date:	
TPA Completed:				Date:	
Provider is 837 Certified:				Date:	
TCM Certified (TCM Contract):				Date:	
Approved by:				Date:	
Denied by:		Reason:		Date:	