COLORADO
Department of Health Care Policy & Financing

3rd PARTY – BIDM DATA ANALYTICS PORTAL ACCESS REQUEST

This New, Modification, and Revocation Request will be used to create, modify, or terminate access to the systems the Department administers or maintains. "Modification" means current system access privileges are to be modified – access to certain systems can be revoked, and/or access to additional systems can be requested. "Revocation" means ALL system access privileges will be revoked. The Request must be completed in full, or it cannot be processed. Incomplete applications will be returned for additional information which may delay access. PLEASE PRINT CLEARLY. No User IDs will be provided until the User has signed the System User Agreement. **Managers must immediately notify the HCPF Information Security Unit to terminate account access for any user no longer authorized to perform required obligations and responsibilities within the system.** Any questions should be directed to the HCPF Information Security Unit at hcpfsecurity@state.co.us.

Please return completed form to: Your HCPF Contract/Program Manager. HCPF Contract/Program Manager will open an OIT Service Desk ticket for processing.

Section 1 – Type of Request

* Type of Request: ☐ New ☐ Modification ☐ Reactivation ☐ Revocation ☐ Transfer
☐ Name Change - Previous Name: ____________________

Effective Date (If left blank, it is assumed to be immediate): ____________________

Section 2 – Individual's Information

All information provided is used solely for the purpose of providing system access or to verify User's identity for resetting passwords.

*First Name: ____________ *Middle Initial: ______ *Last Name: ____________

*List any 4-digit numeric identifier: ____________ *Work Phone: ____________

*Individual's Physical Work Address/City/Zip: ____________________

*Work Email Address: ____________________

Section 3 – Entity Information

*Entity Name: ____________________ *Entity Phone Number: ____________

*Entity Physical Address/City/Zip: ____________________

* Medicaid Billing Provider ID (if more, use supplemental spreadsheet): ____________________

*Entity Type: ☐ PCMP / Provider ☐ Managed Care Entity / RAE

Other - If other, please describe: ____________________

Section 4 -System Access Request, Modification, or Revocation(s)

Please indicate which systems require access modification or revocation and current User IDs. If modification is being requested, please be specific as to what modification is necessary.

BIDM Existing BIDM User ID, if applicable: ___________________________

PCMP (Primary Care Medical Providers) and RCCO / RAE Entities should only be granted access to the following, as needed:

Data Analytics Portal ☐ PHI (Default)

MOVEit (FTP) ☐ Default access *only* applicable to RAE's

Token Selection for Data Analytics Portal

☐ Hard-token (FOB), or

☐ Soft-token, (please select platform):

☐ PC (Windows) ☐ Android ☐ MAC (laptop/desktop) ☐ IOS (iPhone)

Other Systems (Please Specify) - ____

Section 5 - Comments

Access requests **MUST** be tied to a job duty, and only the minimum access necessary to perform job duty, is allowed. Please specify any special exemptions or comments below:

Section 6 - Authorization

ATTENTION – 3rd Party User - These signatures must be collected PRIOR to submitting the form to the HCPF Contract / Program Manager. Requests for access without all required signatures will not be completed.

By signing, the signees attest that information provided is accurate, all access requested is the minimum access necessary to perform employee's authorized responsibilities, and a request to remove all prior access no longer needed has been submitted.

*Manager Name: ______________________________________ *Phone: ________________________

*Manager Email address: ____

*** Manager Signature: ____ *Date: _____________**

* Entity Security Administrator Name:______________________________________ *Phone: ___________________

*Entity Security Administrator Email address: ____

*** Entity Security Administrator or**
Contract / Program Manager Signature: ___________________________________ *Date: ______________

ATTENTION – HCPF Contract / Program Manager - These signatures must be collected (if applicable) PRIOR to submitting the form to the OIT Service Desk. Requests for access without all required signatures will not be completed.

*** HCPF Contract / Program**
Manager Signature: ____ *Date: _____________

Additional Authority Approval: ____ Date: ______________

Section 6 - System User Agreement

(Sign Agreement Only If Requesting Additional, Modification, or Reactivation)

By signing this Agreement, you consent and agree to be bound by all of the terms and conditions below, and you understand that any failure to comply with the terms and conditions may result in sanction, which can include termination of your user account. This Agreement applies to any/all systems you are granted access to by the Department of Health Care Policy and Financing. Completion of this Agreement is required before access will be granted. System users are responsible for reading and complying with any/all applicable Department Privacy/Security Policies and Procedures as provided by the Department.

System users understand that the Colorado Department of Health Care Policy and Financing (Department) owns, either solely or jointly with another State agency or Vendor, the system application and all information that can be accessed through the system. Access to the system is restricted to those who have been authorized by the Department and their Security Administrator to enter.

System users shall only use/disclose records and/or information that is created, received, maintained, or transmitted within the system as authorized by the Department, and/or as required to perform authorized obligations and responsibilities. System users shall limit use/disclosure of records and/or information concerning Colorado Medical Assistance Program clients or applicants to the purposes directly connected with the administration, operation, or oversight of the Colorado Medical Assistance Program. System users shall not make unauthorized use/disclosure of, or knowingly permit unauthorized access by others to, records and/or information contained within the system.

System users shall maintain an assigned, unique User ID. Users understand that they are responsible for any activity that occurs under their individual User ID. In the event that a User suspects that another person knows and/or has used his/her User ID and Password, the User must notify his/her Security Administrator immediately. Additionally, it is a security violation for a User to mask his/her identity or assume the identity of another User. System users shall practice adequate Password management by keeping Passwords confidential. Users shall not share their Passwords with anyone else for any reason, and are discouraged from writing down their Passwords and posting in view of others.
System users understand that the Department may monitor, track, and record all Users and uses of the system at any time. (This includes all Internet usage and email, when Department connection is utilized.) System users shall not knowingly cause or allow the addition, modification, destruction or deletion of any records and/or information accessible through the system, except solely in the course of performing their authorized work. System users shall not attempt to alter, exploit, or otherwise interfere with the system application. The State/Department has the right to update the system at any time. System users shall report any violations, or suspected violations of this Agreement immediately to their Supervisor and/or Security Administrator. System users who are also State employees shall not use state time, property, equipment, or supplies for private profit or gain, or for any other use not in the interest of the State of Colorado. The Department reserves the right to edit/update this Agreement at any time.

*Individual Name (First, MI, Last): ____

*Individual Signature:____*Date: ____________