

Provider Access Request Form

FILL OUT BELOW, PRINT, SIGN AND DATE, then FAX or MAIL to ABOVE.

Group / Practice Name

Tax ID

Address 1

Address 2

City

State

Zip

Phone

Fax

Authorization for Request

First Name

Last Name

Contact Phone

e-Mail

Security Question

Response

Provider Access (check only ONE):

Group Access (All Providers under this TAX ID)

Individual Access (Access a SINGLE Provider under this Tax ID)

List Provider:

By signing this form, you request access and additionally accept responsibility for all system access granted as required by HIPAA regulations. You also accept responsibility to maintain and change passwords at both regular intervals (system enforced) and when there are personnel changes at your group/practice. You agree to provide an updated form with any change to this registration.

This request will be reviewed and verified within 10 business days (excluding holidays). Submission of this form does not guarantee access.

Requestor's Signature (Required) _____ Date ____/____/____