IN Physicians Group

Innovative Management Systems

Full Access / Administrator
Provider Portal Access

Name of Group / Organization | **Organization Tax ID**

First Name | **Last Name** | **Title**

Street Address | **City** | **State** | **ZIP Code**

Email | **Phone Number** | **Fax Number**

Check the following Roles for Provider Portal access:

☐ **Portal Administrator (Professional)** - Main Portal Administrator Account for Professional Claims
- ❖ *Includes access to Authorizations, Claims, Eligibility, Payment Information & reports*

☐ **Portal Administrator (Institution)** - Main Portal Administrator Account for Institution Claims
- ❖ *Includes access to Authorizations, Claims, Eligibility, Payment Information & reports*

- ✓ I understand by signing this form, I am accepting my role as an Administrator with full access to the Provider Portal – including but not limited to Authorizations, Claims (Professional/Institution), Eligibility, and Payment information.
- ✓ I understand I have a unique username and password that cannot be shared. If I have any issues logging on or forget my password, I will contact Innovative Management Solutions (IMS) for assistance.
- ✓ I understand IMS will set up and train [organization] only. Organization is responsible for all other tasks.
- ✓ I understand my role as an Administrator is to assign and manage Organization's user access to the Provider Portal. The Administrator will determine who within the Organization will be added or deleted. The Administrator will also assist with any internal password resets - including any 3rd party billing companies and stakeholders. IMS will assist only at Administrator's request.
- ✓ I understand by signing this form, I am ensuring confidentiality of health information and data in accordance to HIPAA.

Authorized Administrator / Provider Name (Print) | **Signature / Date**

Complete and return form to providerrelations*@imsmso.com*