

Limited Access / Staff  
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:**

- Authorizations** - (Submit, status, access to approval/denial letters)
- Payment Information**
- Claims (Institution)** - (claims status, and pending requests for additional information, ability to submit additional documentation)
- Claims (Professional)** - (claims status, and pending requests for additional information, ability to submit additional documentation)
- Eligibility**

- ✓ I understand that in order to receive access to Provider Portal, I must first get permission from my Administrator.
- ✓ I understand I have a unique username and password that cannot be shared. Anyone who needs access to Provider Portal should work directly with Organization's Administer(s).
- ✓ I understand that Innovative Management Solutions (IMS) will set up and train [organization] only. Organization is responsible for all other tasks.
- ✓ I understand that the login and any secure portal information given to me will not be shared with anyone. All issues relating to log-on or password resets will be sent to Organization's Administrator for assistance.
- ✓ I understand that by signing this form, I am ensuring confidentiality of health information and data in accordance to HIPAA.

Authorized Staff (Printed)

Signature / Date

Administrator (Printed)

Administrator Signature / Date

Complete and return form to [providerrelations@imsmsso.com](mailto:providerrelations@imsmsso.com)