Vitruvian Care

Innovative Management Systems

Limited Access / Staff Provider Portal Access Form

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@imsmso.com