



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...
I understand I have a unique username and password that cannot be shared...
I understand IMS will set up and train [organization] only...
I understand my role as an Administrator is to assign and manage Organization's user access...
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 Stephanie Serrano sserrano@allunitedipa.com