

**CIM Access Request**

**\*\*ATTENTION THIRD PARTY CONTRACTORS\*\***

**Please submit a copy of your executed Business Associate Agreement for each vendor you are requesting access to.**

*Forms that are not legible and/or are missing required info/documentation will not be processed.*

**Are you a Third Party Biller? YES  NO**

**If so, Billing Company:**

|  |  |
| --- | --- |
| **Last Name:** | |
| **First Name:** | |
| **Office:** | |
| **Tax ID:** | **NPI:** |
| **Address:** | |
| **City:** | **State:** |
| **County:** | **Zip:** |
| **Office Phone:** | **Fax:** |
| **Email:** | |
| **Job Title:** | |

**Access Type:**

Eligibility

Referrals/Authorizations

Billing

**Carriers:**

ATRIO Health Plans

Aspire Health Plan

Primary Health CCO

Willamette Valley Community Health CCO

Health Share of Oregon CCO (eligibility tool only)

Legacy ED Call

Tuality Health Alliance

Mental Health (specify MH carriers needed)

Dental(CDC, ADC, MDC, FDC)

**Please email completed form to: support@phtech.com**

**Watch our training video:** [**https://www.youtube.com/watch?v=CV-EgCon-B4**](https://www.youtube.com/watch?v=CV-EgCon-B4)