

**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

[x]  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)