Universal Healthcare

Provider Portal User Access Form Due by:

(A) Contracting Provider/Vendor Information (Must be completed):

Organization/ Provider Name: | NPI | Tax ID

User First Name: | User Last Name:

Existing User? (Please Check one) ☐ YES ☐ NO

(B) Type of access requesting (Required):

☐ Request / Verify Status of Authorization

☐ Verify Status of Claim Explain:

☐ Eligibility verification

☐ _____

This form must be completed and returned within 3 business days of receipt

(C) User Personal Details (Must be completed):

Title	Department
Direct Phone #	Fax #
	Work Email

(D) User Acceptance of Terms of Use I accept the Provider Portal Responsibilities and Terms and Conditions (see attach attest that the above details are correct. Must be completed

Name (Please print)	
Signature	Date

(E) Organization Authorized Manager or Delegate Approval (Users DO NOT sign own form, unless sole proprietor)
I approve this request and verify that these details are correct.

Full Name (Please print)	Signature	Date
Contact Number / E-mail	Organization Address	
Organization City / State		Zip Code

⇨***Please send form via e-mail to Customer_Service@uhcmso.com.***

UHCMSO Use Only

Received By/Date		*Approved By/Date*
Processed By/Date		USER NAME:
USER ACCESS TERMINATION	*Last Activity Date*	*Deactivation Date*