Attachment A
ccLink Provider Portal Access Request

PLEASE TYPE DIRECTLY INTO THE FILLABLE FORM*

***Please Email completed agreement and form to CCHP Portal Support at CCHPPortalSupport@cchealth.org**

Location Name: _____ NPI: _____

_____ _____ _____ _____ _____
Street Suite City State Zip

***Primary Point of Contact:** _____ _____ _____ _____
Name Phone Fax Email

***Please note:** The role of the Primary Point of Contact is to coordinate and manage the users who have ccLink Provider Portal access privileges at your location. The Point of contact will also be the receiver of log on information for the staff listed on this form. This information will be sent to you electronically from CCHP Portal Support and will need to be forwarded to each user on this form.

****For Billers-Please indicate the tax ID number and NPI(s) of the groups you are contracted with to bill CCHP. If you have more than one billing provider please see next page.**

Billing Provider's Tax ID: _____

Billing Providers NPI(s): _____ _____ _____

- List each individual to be assigned privileges to ccLink Provider Portal in the table below.
- When choosing Role, please pick one of these four choices: Provider (i.e. MD, PA, PH.D, etc.), Nurse, Office Staff, or Manager. **Note:** Office staff role does not permit access to clinical information.

Please select all that apply from the following options:

- Requesting Access to: ☐ **Entry of Prior Auths / Referrals / Face Sheets** ☐ **Claims Entry** ☐ **Review of Eligibility / Referrals / Claims**

Customer Name			Role	Phone	Email	Add User?	Delete User?
Last	First	MI					

Authorizing Signature _____ **Date** _____

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Address must be unique, can't be any of the previous addresses listed

Billing Provider Address 2:

Street	Suite	City	State	Zip

Billing Provider's Tax ID(s): _____

Billing Providers NPI(s): _____ _____ _____

Address must be unique, can't be any of the previous addresses listed

Billing Provider Address 3:

Street	Suite	City	State	Zip

Billing Provider's Tax ID(s): _____

Billing Providers NPI(s): _____ _____ _____

Address must be unique, can't be any of the previous addresses listed

Billing Provider Address 4:

Street	Suite	City	State	Zip

Billing Provider's Tax ID(s): _____

Billing Providers NPI(s): _____ _____ _____

Address must be unique, can't be any of the previous addresses listed

Billing Provider Address 5:

Street	Suite	City	State	Zip

Billing Provider's Tax ID(s): _____

Billing Providers NPI(s): _____ _____ _____

Address must be unique, can't be any of the previous addresses listed

Billing Provider Address 6:

Street	Suite	City	State	Zip

Billing Provider's Tax ID(s): _____

Billing Providers NPI(s): _____ _____ _____

Address must be unique, can't be any of the previous addresses listed

Billing Provider Address 7:

Street	Suite	City	State	Zip

Billing Provider's Tax ID(s): _____

Billing Providers NPI(s): _____ _____ _____

Address must be unique, can't be any of the previous addresses listed

Billing Provider Address 8:

Street	Suite	City	State	Zip

Billing Provider's Tax ID(s): _____

Billing Providers NPI(s): _____ _____ _____

Address must be unique, can't be any of the previous addresses listed

Billing Provider Address 9:

Street	Suite	City	State	Zip

Billing Provider's Tax ID(s): _____

Billing Providers NPI(s): _____ _____ _____

Address must be unique, can't be any of the previous addresses listed

Billing Provider Address 10:

Street	Suite	City	State	Zip

Billing Provider's Tax ID(s): _____

Billing Providers NPI(s): _____ _____ _____