

PROVIDER LOGON ID REQUEST FORM FOR WEB-BASED APPLICATIONS

Please take a few minutes to complete this request form so that you and your staff can take full advantage of the services available to your organization through our secure web-based applications.

Submit the completed form electronically by using the **SUBMIT** button at the bottom of this page.

If you are having trouble with the submit button, save this document to your computer, complete it, and:

<p>Return by email to: ProviderRelations@coaccess.com</p>	<p>or</p>	<p>Return by mail to: Provider Relations PO Box 17580 Denver, CO 80217-0580</p>	<p>or</p>	<p>Return by Fax: (303) 755-2368 Attn: Provider Relations</p>
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On our website, you can:

- Verify eligibility of members
- View claim status
- Enter CCAR (Access Behavioral Care (ABC) providers only)
- Clinic reports (Primary care providers only)

On the following pages, please list the name of the clinic or facility, and each of the staff members in need of access to our web-based applications.

- Each person will need their own login to access the secure applications.
- Each person's login is specific to the Tax ID number submitted on this form. If you have staff members who need access for more than one Tax ID number, please submit forms for each applicable Tax ID number.
- Attach additional pages if needed.



OFFICE INFORMATION

Office/Clinic Name			
Date			
Tax ID Number (TIN)			
Address Line 1			
Address Line 2			
City, State, Zip Code			
Primary Contact		Email	
Phone		Fax	
Technical Contact		Phone	
Providing service in accordance with the following Colorado Access Lines of Business (check all that apply):			
<input type="checkbox"/> Access Behavioral Care			
<input type="checkbox"/> CHP+ SMCN <input type="checkbox"/> CHP+ offered by Colorado Access			

USER INFORMATION

First/Last Name			
Position/Title			
Phone			
Email (required)			
<input type="checkbox"/> CCAR (ABC Clinicians Only) <input type="checkbox"/> Eligibility <input type="checkbox"/> Claims Status <input type="checkbox"/> Clinic Reports (PCP only)			

First/Last Name			
Position/Title			
Phone			
Email (required)			
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USER INFORMATION CONTINUED

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