User Access & Updates Request Form
Community Provider and Staff Portal

This is a writeable PDF form. Fill out one form per requestor, save and E-mail completed forms to:
AMACareLinkAccess@ardenthealth.com

This Access Request MUST be completed by a Supervisor or Manager.

- Patient lists in CareLink are dependent on having a full provider roster loaded. Medical practices must provide a complete provider roster for their location. Please attach to the email with your Access Request Form(s). Please provide all of the information to avoid delays.
- **Required for every request:**
  - o Valid email address. This must reflect a private professional email (i.e. sally.jones@privatepractice.com).
  - o The last 4 digits of your SS#. This will be used as your security question validation.
  - o Phone and Fax numbers.
- **Required** for every **Provider** request:
  - o The NPI and Taxonomy fields. The NPI, Taxonomy can be found on this website: https://nppes.cms.hhs.gov/NPPESRegistry.
  - o The Preferred Communication Method field. Providers can choose whether they want to receive their communications via fax or from inside the CareLink InBasket.
  - o The provider's Direct Address field. Direct addresses look similar to an email address and provide a secure, HIPAA-compliant method of transmitting patient health information.

This section must be completed by Supervisor or Manager of the facility		
Supv/Mgr Name:	Phone Number:	Supv/Mgr Email:
Date Requested:	Facility Name:	
Detailed Description of job duties for accessing this site: (Required for access)		
Have you had access to any of our facilities portals in the past: ☐ Yes ☐ No		

Type of Request: ☐ New Account Request ☐ Update Current Account ☐ Deactivate Access
Note: If requesting a new account and this person is replacing an existing account (i.e. former employee), please list name(s) that should be deactivated here:

I will be accessing the Portal as a (choose the access that best encompasses your job role): CHOOSE ONLY ONE

- ☐ Physician/Provider
- ☐ Clinical Support Staff (only RN, LPN/LVN, MA, Surgical/Referral Schedulers)
- ☐ Psych Professional
- ☐ Front Desk
- ☐ Biller/Coder
- ☐ Research Study Monitor
- ☐ Chart Prep Clerk
- ☐ Management
- ☐ Clinical/Medical Student Rotation Start Date End Date
- ☐ Other, please explain:

Continued Care Service Coordination (CCSC) applicants - if your location accept patients via Referral from our facilities Case Management, please select one of the choices below.

☐ CCSC- Vendor Staff (Referral Acceptance Staff Only for - DME, IV Infusion, Outpatient Therapy/Rehab, Dialysis)

☐ CCSC- Clinical Staff (Admission Staff & Backup Only for - Home Health Care, Home Hospice, SNF/NH, LTAC, Acute Rehab)

☐ CCSC - Pharmacist (Pharmacists Only for - Home Health Care, Home Hospice, SNF/NH, LTAC, Acute Rehab

Health Insurance Company applicants - please select the choice below that best encompasses your job role. Patient search will be limited to those patients affiliated with your health plan.

☐ Insurance Company Rep Case Management/Utilization/Claims Staff ☐ Insurance Company Rep Auditor Staff

Provider Requesting Access Section – this section is for providers/physicians only		
Last Name & Suffix: (Sr, Jr, III, etc.)	First Name: (As appears on Medical License)	MI:
Title: (MD, DO, CFNP etc.)	Provider Billing Number (NPI):	DEA Number:
Professional email:	Last 4 digits of SS#:	Gender: ☐ M ☐ F
Provider Billing Specialty:		Provider Billing Taxonomy:
State License Number:		License Exp Date:
Practice Name:		
Address:		
Address 2:		
City	State:	Zip
Phone:	Fax:	Preferred Communication Method: ☐ In Basket Message ☐ Fax

Secure Direct HISP Address - this section is for providers/physicians only (e.g. b.wells@direct.aclinic.org – this is not an email address. Contact your Helpdesk for your direct address.)
Direct Address:

Staff Requesting Access Section – this section is for all non-provider users.			
Last Name & Suffix: (Sr, Jr, III, etc.)	First Name:	MI:	Gender: ☐ M ☐ F
Credentials: (RN, MA, LPN, etc.)	Job Title/Role:		Last 4 digits of SS#:
Practice Name:	Address:		
Address 2:			
City:	State:	Zip:	
Phone:	Fax:	Professional email:	
User Context Number: (Internal use)			