

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:
TULCareLinkAccess@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: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Type of Request: <input type="checkbox"/> New Account Request <input type="checkbox"/> Update Current Account <input type="checkbox"/> 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		
<input type="checkbox"/> Physician/Provider		
<input type="checkbox"/> Clinical Support Staff (only RN, LPN/LVN, MA, Surgical/Referral Schedulers)		
<input type="checkbox"/> Psych Professional		
<input type="checkbox"/> Front Desk		
<input type="checkbox"/> Biller/Coder		
<input type="checkbox"/> Research Study Monitor		
<input type="checkbox"/> Chart Prep Clerk		
<input type="checkbox"/> Management		
<input type="checkbox"/> Clinical/Medical Student Rotation	Start Date	End Date
<input type="checkbox"/> 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: <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> In Basket Message <input type="checkbox"/> 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: <input type="checkbox"/> M <input type="checkbox"/> 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)											