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. The first person requesting access from a medical practice needs to provide a complete Provider Roster for their location. Please attach to the email with your Access Request Form (s). The form may not be processed if it is incomplete, please provide all of the information to avoid delays.
- **Required** for every request:
  - Valid email address. This must reflect a private professional email (i.e. sally.jones@privatepractice.com)
  - The last 4 digits of your SS#. This will be used as your security question validation.
  - Phone and Fax numbers
- **Required** for every **Provider** request:
  - The NPI and Taxonomy fields. The NPI, Taxonomy can be found on the website https://nppes.cms.hhs.gov/NPPESRegistry
  - The Preferred Communication Method field. Providers can choose whether they want to receive their communications via FAX or from inside the CareLink InBasket.

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** (RN, LPN, MA, Surgical/Referral Scheduler **ONLY**)
- ○ **Clinical / Medical Student- Rotation Start Date:** _____ **Rotation End Date:** _____
- ○ **Front Desk**
- ○ **Biller/Coder**
- ○ **Research Study Monitor**
- ○ **Continued Care Service Coordination Vendor Staff** (Referral Acceptance Staff Only, DME, IV Infusion, Outpatient Therapy/Rehab, Dialysis)
- ○ **Continued Care Service Coordination Clinical Staff** (Admission Staff & Backup Only, Home Health Care, Home Hospice, SNF/NH, LTAC, Acute Rehab)
- ○ **Chart Prep Clerk**
- ○ **Management**
- ○ **Psych Professional**

○ **Insurance Company Representative (*choose one*)** ○ **Case Management/Claims Staff** ○ **Audit Staff**

○ **Other, please explain:**

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: (Required)	Last 4 digits of SS#: (*Required*)	Gender: ○ M ○ F	
Provider Billing Specialty:	Provider Billing Taxonomy:		
State License Number:	License Exp Date:		
Practice Name:	Address:		
Address 2:	City:	State:	Zip:
Phone: (*Required*)	Fax: (*Required*)	**Preferred Communication Method:** ○ In Basket Message ○ Fax	

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#: (*Required*)	
Practice Name:	Address:		
Address 2:	City:	State:	Zip:
Phone: (*Required*)	Fax: (*Required*)	Professional email: (Required)	
User Context Number *(Internal use)* :			