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

SECTION 1

Completed by: (if not requestor)	Phone Number:	Requestor's Email:
☐ New Request ☐ Update ☐ Deactivate		
CareLink Portal Access: ☐ Provider ☐ Clinical Support ☐ Front Desk ☐ Biller/Coder ☐ Study Monitor ☐ Surgery Scheduler ☐ 3rd Party Contractor		
Date Requested:	Reason for Request:	

SECTION 2 - This section must be completed for one section NOT BOTH to process.

Provider Requesting Access Section

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:
Epic ID: *(Required if an Update)*	Last 4 digits of SS#: (Always *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:	Fax:	Professional email Required:

Staff Requesting Access Section

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