



Accountable Healthcare IPA

PROVIDER MEMO

*****VERY IMPORTANT, PLEASE READ*****

Response MUST be received!

- Please allow up to **10 working days** for your user name and password to be mailed/faxed out to you.
- If you have already faxed and/or received your assigned user name and password, please disregard this notice.

Update: November 28, 2011, gb

To: All Contracted Provider

RE: Web Based System Authorization Release Form.

As users of the On-LineWeb Based System, it is necessary to sign a release form authorizing your staff to access the system! EZ CAP is linked to the System which allows automated eligibility, authorizations and claims function, via Web-Based. You must be a **contracted** provider to access the provider portal. With the Provider Based Module, you will be able to **view and/or submit**,

- ✓ **Patient Eligibility**
- ✓ **Authorizations**
- ✓ **Claims**

Please take a moment to **review, complete and fax** the attached authorization release form to **(562) 216-5437**. Please limit the number of staff accessing the System to only 3 staff members per physician at this time.

Once we receive your completed form, a user name and password will be assigned to you so you can start using our Web Based System via www.ahcipa.com.

- The physician must sign the authorization release form if the system will be accessed at the PCP or Specialist office.
- An Administrator or Manager must sign the authorization release form if the system will be accessed at the hospital or other facility.

Sincerely,

Grant Bondoc

Information Services

Ph: (562) 435-3333

e-mail: gbondoc@ahcipa.com



Accountable Healthcare IPA

Goodale Web Based Provider Authorization Release Form

Please check one: Primary Care Physician Specialist Ancillary

Contracted Physician Name: _____

Contracted Group Name (if applicable): _____

City: _____ **TAX ID # :** _____

Phone: _____ **Fax:** _____

Office Contact Name: _____ **Email:** _____

By signing the Goodale Web Based Authorization Release form below, I authorize my staff access to patient records and to view and/or process eligibility, authorizations and claims via web based through Accountable Health Plan.

Employee Full Name & Title:
(Please print clearly)

Employee Signature:

<p>1. _____</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">Eligibility</td> <td style="width: 10%;">Yes <input type="checkbox"/></td> <td style="width: 10%;">No <input type="checkbox"/></td> </tr> <tr> <td>Authorizations</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>Claims</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> </table>	Eligibility	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Authorizations	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Claims	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<p>_____</p>
Eligibility	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
Authorizations	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
Claims	Yes <input type="checkbox"/>	No <input type="checkbox"/>								

<p>2. _____</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">Eligibility</td> <td style="width: 10%;">Yes <input type="checkbox"/></td> <td style="width: 10%;">No <input type="checkbox"/></td> </tr> <tr> <td>Authorizations</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>Claims</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> </table>	Eligibility	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Authorizations	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Claims	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<p>_____</p>
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Authorizations	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
Claims	Yes <input type="checkbox"/>	No <input type="checkbox"/>								

***Physician/Administrator Signature:**

Date:

1. _____

2. _____

*Physician Signature is required. User Name and Passwords will not be distributed without the physician signature. **Fax completed form to (562) 216-5437.**