QualChoice® HEALTH INSURANCE

Provider Portal User Access Form

Directions: The provider's designated Portal Administrator (PA) must complete this form to assign, change, or delete a user. Once received, we will send the user a temporary password. The first time the user accesses the portal, he/she will be prompted to change the temporary password to a permanent password.

All fields must be completed.

Section I. Provider Information

Provider Name	Provider NPI No.	Provider TIN

Section II. Portal Administrator

Portal Administrator Name (Last, First, MI)	Email	Work Phone No

Section III. Authorized User(s)

☐ Add ☐ Change ☐ Delete	Name				
	User ID	Max length: 30 characters			
	Email				
	Phone		Last 4 digits of SSN		Date of Birth (MM/DD/YYYY)
☐ Add ☐ Change ☐ Delete	Name				
	User ID	Max length: 30 characters			
	Email				
	Phone		Last 4 digits of SSN		Date of Birth (MM/DD/YYYY)
☐ Add ☐ Change ☐ Delete	Name				
	User ID	Max length: 30 characters			
	Email				
	Phone		Last 4 digits of SSN		Date of Birth (MM/DD/YYYY)
☐ Add ☐ Change ☐ Delete	Name				
	User ID	Max length: 30 characters			
	Email				
	Phone		Last 4 digits of SSN		Date of Birth (MM/DD/YYYY)

Section IV. Authorized Signature

By way of signature below, I authorize the addition, deletion or change of users as listed in Section III.

Provider Portal Administrator Signature	Date Signed (MM/DD/YYYY)

Section V. Instructions

Mail	Fax	Email
QualChoice Attn: Business Unit P.O. Box 25610 Little Rock, AR 72221	833.696.1937	qc_bs_pr@qualchoice.com

QualChoice® HEALTH INSURANCE

Provider Portal Administrator Designation

Our Provider Portal offers secure online access for healthcare providers to handle daily business transactions. The portal is governed by a strict access policy to make sure that no PHI is inappropriately distributed. Each user will have a separate secure account.

Directions: Use this form to designate, change, or delete a primary Portal Administrator (PA). Only a PA has the authority to assign and control access to other users.

Once a PA is designated, he/she would need to fill out the *Provider Portal User Access Form* for each user needing access to claim information and authorization and eligibility inquiries.

All fields must be completed.

Section I. Provider Information		
Provider Name	Provider NPI No.	Provider TIN
Section II. Portal Administrator		
☐ New ☐ Change ☐ Delete	Effective Date (MM/DD/YYYY):	
Portal Administrator Name (Last, First, MI)		
Email	Work Phone No.	
To ensure we are communicating with the designated Portal Administrator, please provide a Password. (Max length: 30 characters)		
Portal Administrator Signature	Date Signed (MM/DD/YYYY)	
Section III. Authorized Signature		
By way of signature below, I designate the individual named in Section II as the Portal Administrator for the provider named in Section I. This individual has the authority to add, change, and terminate employees' access to the QualChoice Provider Portal.		
Print Name	Title	
Signature	Date Signed (MM/DD/YYYY)	
Section IV. Instructions		
Mail	Fax	Email
QualChoice Attn: Business Unit P.O. Box 25610 Little Rock, AR 72221	833.696.1937	qc_bs_pr@qualchoice.com