Primary Care/Specialist/Ancillary Provider
Internet Password Release Form

Provider Instructions:	**Section 1: Select only one box** **Section 2: Complete applicable information, sign and date**

Section 1: Please select one box

- ☐ Yes, I wish to have access to the Internet Based Provider Module
- ☐ I already have access but am requesting to add/delete staff members

Section 2: Please complete applicable fields

Group Name:
Tax ID Number:
Please note, we are unable to process this request without the Group/Organization Name and Tax ID#

	First and Last Name	**PCP/Specialist, Job Title and/or Department**
Physician Name:		
Authorized Staff:		
Address:		
Phone and Fax:		
E-mail address: (Required)		

Sign Here. **Date**

Please complete all fields <u>legibly</u> or else access will be denied.

*****DO NOT FAX THIS FORM*****

You may <u>only</u> email this form or the TIN and first/last names of all users to Provrelations@coasthealthcare.net. You will receive instructions, usernames and passwords within approximately one week.