

## Centricity EMR/PM Access Request Form

~~ Each user must also sign an INHS Security Agreement. ~~

**Instructions: All fields must be filled out / completed.**

Request Reason : **New User**  **Remove User**  **Update User**

**Access Activation Date:** \_\_\_\_\_ **Access Deactivation Date:** \_\_\_\_\_

Clinic Information:

**Clinic Name :** \_\_\_\_\_

**Contact Person :** \_\_\_\_\_ **Title :** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax :** \_\_\_\_\_ **Email :** \_\_\_\_\_

User Information:

**Username** (required for Remove or Update User request) : \_\_\_\_\_

**Email Address** (required for Secure Email and Direct Messaging) : \_\_\_\_\_

First Name / Middle Initial / Last Name / Credentials (MD, ARNP, RN etc)\*:

**Work Phone :** \_\_\_\_\_ **Last SSN #** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Specialty** \_\_\_\_\_

**Home Location of Care** \_\_\_\_\_

**Additional Location of care(s) needed:** \_\_\_\_\_

Access Needed:  EMR Only  PM Only  Both EMR and PM Access

**Access Similar to:** \_\_\_\_\_ **View Only Access:**

Provider Setup: *The below fields are required to ADD New or REMOVE a Provider (MD, DO, ARNP, PA-C etc.).*

**\*\* This access form will constitute notification to IRM of the need for an additional EMR license and/or inactivation of a license. This will be reflected on your monthly Server Farm Billing statement. \*\***

**New Provider:** Full Time  Part Time  Locum  Student

**Clinic interfaces needed:** Yes  No

**Setup Provider for ePrescribing:** Yes  No  **If YES please provide the following information:**

**DEA:** \_\_\_\_\_ **NPI:** \_\_\_\_\_ **Delegate:** \_\_\_\_\_

Meaningful Use Setup

**Eligible Professional:** Yes  No  **Which Program:** Medicaid  Medicare

**Stage-Stage Year:** \_\_\_\_\_ **Reporting Year:** \_\_\_\_\_ **Attested:** Yes  No

**Licensed or Credentialed:** Yes  No

**State of License:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_

**EMR/HIPAA Manager Signature (required):** \_\_\_\_\_ **Date :** \_\_\_\_\_

**\*\*\* Please send the signature page of the INHS Security Agreement with this form for the access to be completed\*\*\***

*Fax completed form to: Attn: INHS / Engage Security – Fax# (509) 232-8287*