ADVENTHEALTH SECURITY REQUEST FOR PAYER ACCESS

**PLEASE INDICATE TYPE OF REQUEST:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | NEW USER |  | FACILITY ACCESS CHANGE |  | TERMINATE | TERMINATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PAYER USER INFORMATION** (all fields must be completed)**:**

|  |  |
| --- | --- |
| LAST NAME |  |
| FIRST NAME |  |
| MIDDLE INITIAL |  |
| PHONE NUMBER |  |
| EMAIL ADDRESS |  |
| DOB |  |
| RN / MD LICENSE # |  |
| SOCIAL SECURITY # |  |
| JOB TITLE |  |
| START DATE |  |
| POSITION REQUESTED | 3RD PARTY PAYER |

**PAYER INFORMATION:**

|  |  |
| --- | --- |
| PAYER/COMPANY/STATE |  |
| \*USER GROUP |  |

**PLEASE INDICATE AHS FACILITIES FOR WHICH THE USER REQUIRES ACCESS:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | ETZ | AdventHealth Carrollwood |  |  | ETZ | AdventHealth Wauchula |
|  | ETZ | AdventHealth Connerton (LTAC) |  |  | ETZ | AdventHealth Wesley Chapel |
|  | ETZ | AdventHealth Dade City |  |  | ETZ | AdventHealth Zephyrhills |
|  | ETZ | AdventHealth Daytona Beach |  |  | ETZ | AdventHealth Gordon |
|  | ETZ | AdventHealth Deland |  |  | ETZ | AdventHealth Manchester |
|  | ETZ | AdventHealth Fish Memorial |  |  | ETZ | AdventHealth Murray |
|  | ETZ | AdventHealth Heart of Florida |  |  | ETZ | AdventHealth Hendersonville |
|  | ETZ | AdventHealth Lake Placid |  |  | CTZ | Texas Health Huguley |
|  | ETZ | AdventHealth Lake Wales |  |  | CTZ | AdventHealth Rollins Brook |
|  | ETZ | AdventHealth New Smyrna Beach |  |  | CTZ | AdventHealth Central Texas |
|  | ETZ | AdventHealth North Pinellas |  |  | CTZ | Central Texas Medical Center |
|  | ETZ | AdventHealth Ocala |  |  | CTZ | AdventHealth Durand (CVH) |
|  | ETZ | AdventHealth Palm Coast |  |  | CTZ | AdventHealth Shawnee Mission |
|  | ETZ | AdventHealth Sebring |  |  |  |  |
|  | ETZ | AdventHealth Tampa |  |  |  |  |
|  | ETZ | AdventHealth Waterman |  |  |  |  |

**AUTHORIZED *PAYER ACCESS* LIAISON SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*OPID: \_\_\_\_\_\_\_\_\_\_\_\_\_ \*COST CENTER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*To be completed by AdventHealth