ABS Provider Portal Addition/Termination Form

Assigned IDs cannot be transferred to other Practices/Locations

To add or remove access to the provider portal, all fields below should be completed, and this application returned to ABS.

Provider Name ___________________________ **Billing TIN** ______________________________________

Practice/Facility Name ____________________

Address _________________________________

City _____________________________________ **State** __________________ **Zip** ________________

In the section below, identify the individuals who you wish to terminate access to the ABS provider portal.

1 ______________________________________ ______________________ ____________________________
Name (First, Last) *Email Address* *Telephone #*

2 ______________________________________ ______________________ ____________________________
Name (First, Last) *Email Address* *Telephone #*

3 ______________________________________ ______________________ ____________________________
Name (First, Last) *Email Address* *Telephone #*

In the section below, identify the individuals who you wish to give access to the ABS provider portal. All individuals using the portal must include email/phone number to receive a user name and password. User names and passwords will be emailed to individual user. User names and passwords must not be shared.

1 ______________________________________ ______________________ ____________________________
Name (First, Last) *Email Address* *Telephone #*

2 ______________________________________ ______________________ ____________________________
Name (First, Last) *Email Address* *Telephone #*

3 ______________________________________ ______________________ ____________________________
Name (First, Last) *Email Address* *Telephone #*

By signing this form the administrator has agreed to sole responsibility for the access of any user above who accesses the ABS provider portal for eligibility and claims information.
BOTH SIGNATURES ARE REQUIRED

____ ________________________________ ___________________
Administrator Signature *Title* *Date*

____ ________________________________ ___________________
Provider/Officer Signature *Title* *Date*

Mail or Fax Completed Application to: ABS for SmartHealth
8220 Irving Road
Sterling Heights, MI 48312
Fax: (586) 693-4321

If you have questions, please call: **(800) 645-9978**