ABS Automated
Benefit Services

ABS LIN System Access Application
Assigned IDs cannot be transferred to other Practices/Locations

To be able to access the LIN system, all fields below should be completed and this application returned to ABS.

Provider Name: _____   **Billing TIN:** _____

Practice/Facility Name: _____

Address: _____

City: _____   **State:** _____   **Zip:** _____

Each TIN number can only have one administrator whose responsibility it is to notify ABS of LIN user additions, changes and terminations. Please name an administrator for the TIN above:

Administrator Name: _____

Email Address: _____   *(Email Address must be provided to receive ID)*

Telephone Number: _____

In the section below, identify the individuals who will need access to the ABS LIN System*. All individuals using LIN 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 #

4: _____   _____   _____
   Name (First, Last)   Email Address   Telephone #

*Please complete second page of this application for additional users.

By signing this form the administrator has agreed to sole responsibility for the access of the any user above who accesses the ABS LIN system eligibility and claims information.

_____   _____   _____
Administrator Signature   Title   Date

_____   _____   _____
Provider/Officer Signature   Title   Date

Mail or Fax Completed Application to:	*If you have questions, please call:*
Automated Benefit Services, Inc. (ABS)	
8220 Irving Road	**800-645-9978**
Sterling Heights, MI 48312 **Fax: (586) 693-4321**	

ABS Automated
Benefit Services

ABS LIN System Access Application Additional Users
Assigned IDs cannot be transferred to other Practices/Locations

To be able to access the LIN system, all fields below should be completed and this application
returned to ABS

Provider Name: _____   **Billing TIN:** _____

Practice/Facility Name: _____

In the section below, identify <u>ADDITIONAL</u> individuals who will need access to the ABS LIN System. All individuals using LIN 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.

5: _____ | _____ | _____
   Name (First, Last) | *Email Address* | *Telephone #*

6: _____ | _____ | _____
   Name (First, Last) | *Email Address* | *Telephone #*

7: _____ | _____ | _____
   Name (First, Last) | *Email Address* | *Telephone #*

8: _____ | _____ | _____
   Name (First, Last) | *Email Address* | *Telephone #*

9: _____ | _____ | _____
   Name (First, Last) | *Email Address* | *Telephone #*

10: _____ | _____ | _____
   Name (First, Last) | *Email Address* | *Telephone #*

11: _____ | _____ | _____
   Name (First, Last) | *Email Address* | *Telephone #*

12: _____ | _____ | _____
   Name (First, Last) | *Email Address* | *Telephone #*

13: _____ | _____ | _____
   Name (First, Last) | *Email Address* | *Telephone #*

14: _____ | _____ | _____
   Name (First, Last) | *Email Address* | *Telephone #*

15: _____ | _____ | _____
   Name (First, Last) | *Email Address* | *Telephone #*