



ABS LIN System Addition/Termination Form
Assigned IDs cannot be transferred to other Practices/Locations

Please use this form to add or remove access to the LIN system and return to ABS

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

Practice/Facility Name: _____

Address: _____

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

Please fill this section out for those that you wish to TERMINATE ACCESS to the LIN System		
1:	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>
	_____	<i>Telephone #</i>
2:	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>
	_____	<i>Telephone #</i>
3:	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>
	_____	<i>Telephone #</i>
4:	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>
	_____	<i>Telephone #</i>

Please fill this section out for those that you wish to GIVE ACCESS to the LIN System		
1:	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>
	_____	<i>Term Date</i>
2:	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>
	_____	<i>Term Date</i>
3:	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>
	_____	<i>Term Date</i>
4:	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>
	_____	<i>Term Date</i>

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 for eligibility and claims information.

Administrator Signature Title Date

Provider/Facility Administrator Signature Title Date

Mail or Fax Completed Application to: Automated Benefit Services, Inc. (ABS) 800 Tower Drive, Suite 300 Troy, MI 48098	Fax: (586) 693-4321	If you have questions, please call: 800-645-9978
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