

Online Claims Access Request

Use this form to request access to the online claims portal to view claims that have been re-priced under your participation agreement with The Alliance. **In order for your request to be processed please make sure both sections of the form are complete.**

Contact Information	
First and Last Name:	Title:
Provider Group/Practice Name:	Tax ID:
Address:	Phone:
Name of Employer if different than Provider Group/Practice:	
Email (required):	
<i>I understand that I am requesting access to claims data that is protected under HIPAA, and that this data may not be used for any other purpose than that permitted by law. Unauthorized use or disclosure of this information may result in civil or criminal penalties. I agree to take appropriate measures to prevent unauthorized use or disclosure and to report any such unauthorized disclosure promptly. I further agree not to share my login information with any other person.</i>	
Signature:	Date:

This request must be signed by an authorized representative of the Provider Group/Practice/Organization (manager, supervisor, director). **For security purposes, the individual authorizing the access must be different than the user** except in cases of sole proprietors. Even in such cases, it is strongly recommended to have a different person authorizing access as this person receives notice of any access changes for registered users.

Authorization Information	
Name:	Title:
Email (required):	
<i>I authorize the requestor to receive claims data on my/our behalf, and agree to notify The Alliance promptly of any changes to this authorization.</i>	
Signature:	Date:

Please return completed form to:

FOR THE ALLIANCE USE ONLY:

Entered in Claims Portal _____

THE ALLIANCE 
Employers moving health care forward

Attn: Provider Relations
PO Box 44365, Madison, WI 53744

Phone: 608.276.6620

Fax: 608.210.6677

Email: providerservices@the-alliance.org