PROVIDER REQUEST
FOR USER NAME AND PASSWORD

Please fax signed form to 405-775-5990 (Attn: Claims Manager).
Once your online access is created, your password will be emailed to you.

Business Name: _____

Tax ID#: _____

User's Name: _____

Position: _____

Address: _____

City, State & Zip: _____

Phone #: _____

Fax #: _____

E-mail: _____

Supervisor's Name: _____

I understand that this site is intended as a secure online source of confidential medical information, protected by federal law. If I share my access ID and password with another person, I accept full responsibility for any unauthorized disclosure of protected health information under the federal regulations, including but not limited to notification of such unauthorized access to Frates Benefit Administrators, and to the patient as required under federal laws governing patient privacy and protection.

I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.

I understand that access to this site is provided as a convenience and that Frates Benefit Administrators has the right to deactivate access to this site at any time for any reason.

I understand that my activities within this site may be tracked by computer audits.

_____ _____

User Signature Date Supervisor Signature Date