abs AUTOMATED BENEFIT SERVICES

ABS Provider Web Portal Access Application

Assigned IDs cannot be transferred to other Practices/Locations

To obtain access to our Provider Web Portal, all fields below should be completed and this application returned to ABS.

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

Practice/Facility Name: _____

Address: _____

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

Each Tax ID number can only have one administrator whose responsibility it is to notify ABS of 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*. All individuals 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 on behalf of any of the users above that are given access to the Provider Web 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:	*If you have questions, please call:*
Automated Benefit Services, Inc. (ABS) **8220 Irving Road** **Sterling Heights, MI 48312** **Fax: (586) 693-4321**	**800-645-9978**

abs AUTOMATED BENEFIT SERVICES

ABS Provider Web Portal Access Application Additional Users

Assigned IDs cannot be transferred to other Practices/Locations

To obtain Provider Web Portal access for member eligibility and claims information, 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 Provider Web Portal. All individuals 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.

	Name (First, Last)	*Email Address*	*Telephone #*
5:			
6:			
7:			
8:			
9:			
10:			
11:			
12:			
13:			
14:			