

**Medicare Part B Professional Provider Telecommunication Network (PPTN)
Access Request Form**

This form is required in order to establish access or remove access to the PPTN system. The Medicare Part B PPTN allows providers access to beneficiary eligibility information directly from the Common Working File (CWF), which contains the same eligibility information available via the 270/271 Health Care Eligibility Benefit Inquiry and Response transaction.

All sections must be completed. If a section is not applicable, then respond with 'N/A'. If additional space is needed, attach a separate sheet.

NOTE: Sharing of IDs and passwords is strictly prohibited and is a violation of CMS regulations. Logon IDs must be terminated when an ID is no longer needed or an employee terminates their employment with the company.

Type of Access Requested

New _____ Date to begin access _____ Confirmation of Current: _____
(Existing users only)

Removal _____ Date to terminate access _____

Indicate the impacted Medicare Part B states corresponding to the billing provider number:

Iowa _____ Kansas _____ Nebraska _____ Missouri _____

User Information (employee who will be using the ID)

User Name _____

EDC ID: _____ Clerk ID: _____
(Existing users ex: Jane Doe's ID is JAD9999) (4 digits)

Provider Name: _____

Provider Street Address: _____

Provider City/ State/Zip: _____

Contact Person: _____
(Printed Name)

Contact Phone #: _____ Contact Fax #: _____
(Please incl. ext #)

Contact Email Address: _____

Provider Identification Numbers:

Multiple providers may be listed on this form if they are at the same location.

Provider Name	Provider Number	NPI Number

Method of Electronic Access

IVANS ____ Vision Share ____ Other (specify) _____

Vendor Information (if applicable)

If the request for access is for a vendor, a letter written on provider letterhead, authorizing the vendor to access provider data, is required. The letter must contain the signature and title of the authorized representative for the provider. Also include the number of users to be set up and the list of all billing provider numbers to be accessed.

Vendor Name _____
Software Product _____
Mailing Address _____
City, State, Zip _____
Contact Person _____
Telephone _____
Fax _____
Email _____

Signature Attestation

As a member of this organization, I have the authority to enter into, administrate, and/or terminate contracts and make related determinations. By signing this document, I verify that I meet the signature requirements and authorize this access request.

Contact Person: _____
(Printed Name) (Signature)

Title: _____ Date: _____