Availity Business Associate Provider Access Delegation Form

Provider Name: _____

Tax ID: _____

Date: _____

I am a Physician, Hospital-Based Physician, Physician Group, or Hospital currently under

contract with _____ILLINOIS PRIMARY HEALTH CARE ASSOICATION (EI-CBO)_____

having offices at __1999 WABASH STE. 200, SPRINGFIELD, IL_62704_____

for medical billing and/or other claims related services.

I do hereby authorize IPHCA (EI-CBO) access to claims and other related information for my patients through their use of the Availity® Gateway. I do hereby affirm that all of the necessary consents have been obtained from such patients to grant access to their claims and other related information to IPHCA (EI-CBO).

Upon the termination of services provided by IPHCA (EI-CBO) to my practice, I understand it is my responsibility to notify Availity through the execution of the *Availity Business Associate Provider Access Termination Form*, which can be provided by the Business Associate currently performing transactions on my behalf or accessed online at www.availity.com.

Provider Name: _____

Title: _____

Signature: _____ Date: _____

PROVIDER TYPE: _____

Enter the Business Associate contact information below so that we may notify your Business Associate that they have access to conduct business on your behalf through the Availity® Gateway.

Business Associate Contact Name: BRENDA WILLIAMS_____

Contact Phone: 1-800-634-8540_____ Ext._____

Contact Email: ___insbillingunit@cquest.us_____