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| **VieWPoint Access Request Form** |
| **As of 10/1/21 new staff should request access to bill via this form for Woodlands, Pines and Van Buren** |
| **I. Request Type:**  CMH:  Woodlands  Van Buren  Pines  User Status:  New User  Delete User  Section II, Section III, Section IV and Section VII must be completed for new user access. Only Section II must be completed to delete user access.  You may also complete Section VI if there are any special requests or notes.    Rendering Provider:  New Provider  Delete Provider  Section V and Section VII must be completed to add or delete Rendering Provider. You may also compete Section VI if there are any special requests  or notes. |
| **II. User Information:**  Title:  Staff Name:  Title:    Email:      Name of Organization: |
| **III.** **External Provider Claim Entry: Requesting Access**   **Yes**   **No**     * Able to enter a provider claim to the CMH using HCFA-1500 or UB-04 claim form. * Able to view authorizations for my organization. * Able to adjudicate claim batches to check for errors before submission to the CMH. * Able to view payments, EOBs and remittance advices. * Able to view the client chart and view Assessments, IPOS documents, Diagnosis and   authorizations. |
| **IV. External Provider 837 Submission: Requesting Access**   **Yes**   **No**   * Able to upload 837 claim file into VieWPoint and view 835 response file. |
| **V. Rendering Provider:**    License Number:  Practitioner Name:    NPI Number:  Credentials: |
| **VI. Notes and Requests:** |
| **VII. Provider Attestation**  I HEREBY AGREE TO IMMEDIATELY NOTIFY CMH PROVIDER NETWORK DEPARTMENT IF STAFF OR RENDERING PROVIDER NAMED ABOVE ENDS EMPLOYMENT OR IF THEY TRANSITION TO A POSITION THAT WOULD NO LONGER REQUIRE ACCESS TO THE CLAIMS SYSTEM FOR THEIR JOB FUNCTIONS. I FURTHER AGREE THAT STAFF USER NAMES AND PASSWORDS MUST BE USED ONLY BY THE PERSON IT HAS BEEN ASSIGNED, VIOLATION OF THIS PROVISION MAY RESULT IN SANCTIONS.  Signature of Supervisor:  Printed Name / Title:  Date: |
| **VIII. Administration Approval (to be completed by CMH staff):**  Date:  Authorized By: |

Please forward completed forms to:

Woodlands: providers@woodlandsbhn.org

Van Buren: [VanBurenProviderSupport@vbcmh.com](mailto:VanBurenProviderSupport@vbcmh.com)

Pines: [PinesProviderSupport@pinesbhs.org](mailto:PinesProviderSupport@pinesbhs.org)