PROVIDENCE Health & Services SWEDISH MEDICAL CENTER KADLEC

HIM Managed Epic Access Request

Form must be complete and legible to be processed

PURPOSE:

☐ Concurrent/Utilization Review ☐ HEDIS ☐ Risk Adjustment

☐ Other: _____

ORGANIZATION:

Name: _____

Address: _____ City: _____ State _____ Zip: _____

Primary Contact Name: _____ Email: _____

INDIVIDUAL INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Birth Date: _____ SSN: _____ (Last 6 Digits) Job Title: _____

Work Phone: _____ Work Email: _____

Previous Network Account? ☐ No ☐ Yes - Login ID: _____

Name of Co-Worker to Mirror? _____

Your SSN and birth date are used to verify your identity for use in password management, access monitoring, and other system administration functions.

You need access to which location(s):

☐ Swedish (WA)
☐ Kadlec (WA)
☐ Providence (OR & CA)
☐ Providence (WA & MT)
☐ Providence (AK)

Manager's Name: _____

Manager's Signature*: _____ Date: _____

* Must sign by hand

3OHDHEPLWWRHDFKORFDWLRZKHUHRHHDFFH:

ZHGLV | Email: HIMAffiliateAccess@Swedish.org | Fax: 206-320-7194

Kadlec | Email: WAKRMCHIM.EpicCareLink@Kadlec.org | Fax: 509-942-3091

r en e | Email: PHSHimEpiccareLink@Providence.org | Fax: 971-712-2172