CMS

Cap Management Systems

Tenet HealthSystems

CAP CONNECT SECURITY REQUEST FORM

☐ ADD NEW ACCOUNT ☐ MODIFY USER ACCOUNT ☐ DELETE USER ACCOUNT: ____________________

SECTION A — **USER INFORMATION – TO BE COMPLETED BY REQUESTOR – REQUIRED**

FACILITY / ANCILLARY PROVIDER NAME:			DEPARTMENT:
USER FIRST NAME	MI	LAST NAME	PHONE:
USER'S TITLE			E-MAIL: (required)
FACILITY ADDRESS/CITY/ST/ZIP			SUPERVISOR NAME:
			SUPERVISOR PHONE:

Security Statement

CMS access privileges are granted to authorized contracted provider/facilities at the lowest possible level pursuant to the efficient performance of their duties and must be used only for CMS authorized business. Computer access devices, such as user identity codes and passwords, remain the property of CMS and are not to be divulged to any other person unless approved by CMS Information Systems Security. Unauthorized access to, use and possession of, removal of, and/or damage to company records is a breach of the CMS corporate policy and may result in disciplinary and/or legal action.

I have read and understood the content of the above Security Statement and agree to accept and abide by the policies stated herein. I agree to keep my access code confidential and to guard the confidentiality of all system information. As an authorized CMS Cap Connect User, I share responsibility for the protection of CMS' information assets and will be held accountable for maintaining their integrity, confidentiality, and availability. Access to data outside of your authorized facility or region is limited due to Federal (JCAHO), Corporate, and Internal Audit guidelines protecting patient confidentiality and data security. Additional authority will be required for these requests. Cap Management Systems reserves the right to pursue legal prosecution under local, state, and federal statutes.

User Signature (Required): ____________________ **Date:** ____________________

SECTION B — **AFFILIATION - LIST NAME OF GROUP OR IPA YOU ARE CONTRACTED WITH**

GROUP / IPA	VENDOR NAME - LIST VENDOR NAME USED WITH GROUP	VENDOR TAX ID

SECTION C — **ACCOUNT TYPE AND ACCESS – SELECT ACCOUNT TYPE AND REQUESTED ACCESS**

ACCOUNT TYPE:

☐ ANCILLARY PROVIDER ☐ HOSPITAL / FACILITY ☐ OTHER ____________________

REQUESTED ACCESS:

☐ AUTHORIZATION INQUIRY & SUBMISSION ☐ CLAIMS INQUIRY ☐ CLAIM SUBMISSION ☐ ELIGIBILITY INQUIRY

SECTION D: — **AUTHORIZATION SIGNATURE**

SUPERVISOR / DEPARTMENT MANAGER SIGNATURE: ____________________ DATE:

NAME: ____________________

SECTION E: — **AUTHORIZATION SIGNATURE – TO BE COMPLETED BY CAP MANAGEMENT SYSTEMS**

CHIEF OPERATIONS OFFICER SIGNATURE: ____________________ DATE:

CHIEF OPERATIONS OFFICER NAME: ____________________

CHIEF INFORMATION OFFICER SIGNATURE: ____________________ DATE

CHIEF INFORMATION OFFICER NAME: ____________________

SECTION F: — **TO BE COMPLETED BY CMS INFORMATION SYSTEMS DEPARTMENT**

SYSTEM ADMINISTRATOR SIGNATURE: ____________________ DATE:

SYSTEM ADMINISTRATOR NAME: ____________________

ASSIGNED USER ID: ____________________ PASSWORD: ____________________

DATE RECEIVED:

DATE COMPLETED: