P.O. Box 30192
Salt Lake City, UT 84130-0192
800-538-5054
selecthealthphysician.org

Select Health

SelectHealth Secure Provider Tools: Login Application

INSTRUCTIONS: Complete this form to request access to secure SelectHealth information, including the **Provider Benefit Tool** for member information such as claims status, member eligibility, and plan information; **CareAffiliate**® to view and submit preauthorization data; **Reports** to review quality improvement, medical home, and population health reports.

Once you complete the form, click on the green **SUBMIT** button (bottom of page 2) to email this application to **providerwebservices@selecthealth.org**.

REQUIRED: The **SelectHealth Information Technology Service Agreement (ITSA)** must also be submitted before you can access our tools. If you have previously signed the ITSA, you do not need to submit a new ITSA with this application.

Questions? Include them in your email, or call Provider Development at **800-538-5054, Option 2**.

A. REQUESTOR INFORMATION (All fields required.)

Office Manager/Contact ______________________________

Medical or Dental Health Care Organization (HCO) Name (provider or practice) ______________________________

Tax Identification Number (TIN) ______________________________

Providers in Clinic ______________________________

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Office Address ______________________ City, State, ZIP ______________________

Area Code/Ph# ______________ Area Code/Fax# ______________ Email ______________

B. USERS REQUESTING ACCESS

List all users in the office who are requesting access. (Additional spaces are available on next page.)

FULL LEGAL NAME	EMAIL ADDRESS	LAST 4 DIGITS SSN	DATE OF BIRTH (MM/DD/YY)	EXISTING USER ID If applicable	REQUESTED ACTION Indicate "New/Add" or "Remove" as well as which tool you are requesting
					New/Add ❑ Remove ❑ Care Affiliate ❑ Reports ❑ Provider Benefit Tool ❑
					New/Add ❑ Remove ❑ Care Affiliate ❑ Reports ❑ Provider Benefit Tool ❑
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					New/Add ❑ Remove ❑ Care Affiliate ❑ Reports ❑ Provider Benefit Tool ❑
					New/Add ❑ Remove ❑ Care Affiliate ❑ Reports ❑ Provider Benefit Tool ❑

C. ADDITIONAL USERS

Office Manager/Contact

Medical or Dental Health Care Organization (HCO) Name

List additional users in the office who are requesting access.

FULL LEGAL NAME	EMAIL ADDRESS	LAST 4 DIGITS SSN	DATE OF BIRTH (MM/DD/YY)	EXISTING USER ID If applicable	REQUESTED ACTION Indicate "New/Add" or "Remove" as well as which tool you are requesting
					New/Add ❑ Remove ❑ Care Affiliate ❑ Reports ❑ Provider Benefit Tool ❑
					New/Add ❑ Remove ❑ Care Affiliate ❑ Reports ❑ Provider Benefit Tool ❑
					New/Add ❑ Remove ❑ Care Affiliate ❑ Reports ❑ Provider Benefit Tool ❑
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