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 __________________[Business Associate]

having offices at ________________________

for medical billing and/or other claims related services.

I do hereby authorize [Business Associate] 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 [Business Associate].

Upon the termination of services provided by [Business Associate] 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: __________

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: ________________________

Contact Phone: (___) ____________________ Ext. __________

Contact Email: ________________________________

Fax completed form to Availity Security at 904.470.2187 or
Mail the completed form to Availity Security for final processing at:
Availity L.L.C., Registration Department, P.O. Box 550857, Jacksonville, FL 32255-0857.