# Electronic Medical Record Intake Access Form
# With Read & Write Privileges

American Choice Healthcare (ACH) is requesting access to your Electronic Medical Record (EMR) to assist you with a variety of operational processes including Coding and Billing, Patient Outreach Scheduling Campaigns, and Embedded Care Management support. American Choice Healthcare commits to communicate any changes in personnel on a timely basis.

Please complete the form and contact your assigned Provider Success Specialist (PSS) if you need clarification or have any questions regarding a particular item within this form.

## General Information

Practice Name: _____ Tax ID: _____

Provider Success Specialist: _____

Email Address: _____ Phone Number: _____

## TO BE COMPLETED BY PRACTICE

Electronic Medical Record: _____

EMR Used for: ☐ Scheduling ☐ Clinical Notes

Practice Management Software (if different): _____

Billing Conducted by: ☐ In-Practice ☐ Outsourced Company

Practice Administrator's Name: _____

Email Address: _____ Phone Number: _____

## EMR Access Technology *(Select all that apply)*

If EMR requires Multi-Factor Authentication (MFA) phone number, use: (786) 610-3700.

☐ Client software installation needed

☐ Remote Desktop Program (RDP): _____

☐ Web Browser-based EMR: _____

☐ Virtual Private Network Required (VPN)

☐ **IMPORTANT NOTE:** By clicking the box, you authorize the creation of individual user accounts. Once access is provisioned in your EMR, please send the initial credentials along with the instructions on how to access your EMR to the specific user.

## Individual User Request

*(We assign two nurses to each practice, one focusing on CCM outreach and the other focusing on TCM outreach)*

The provisioning of your EMR must include Read and Write permission which should include, but not limited to, making or requesting appointments, tasking/messaging providers with prescription refills, or other semi-urgent/urgent patient concerns.

TCM-Focused Nurse: _____

Email Address: _____ Phone Number: _____

CCM-Focused Nurse: _____

Email Address: _____ Phone Number: _____

*(We conduct patient chart audits to ensure the highest level of billing)*

Coding Specialist: _____

Email Address: _____ Phone Number: _____

*(We perform patient outreach for different campaigns and schedule appointments)*

Scheduling Assistant: _____

Email Address: _____ Phone Number: _____

*(We assist with regulatory compliance reporting)*

Quality and Regulatory Analyst: _____

Email Address: _____ Phone Number: _____

**As a qualified representative of the practice, I will ensure that you will support processes in resolving any technical issues that arise in our partnership.**

Completed By (PLEASE PRINT): _____

Signature: _____

Date: _____