



### Provider User Access Agreement

Utah Department of Health, Division of Medicaid and Health Financing

| Section 1 - User Information |                   |                    |
|------------------------------|-------------------|--------------------|
| Name                         | Email address     | UtahID             |
| Employer                     | Department/Office | Job Title          |
| Street Address               | City/State/Zip    | Work phone #       |
| Supervisor Name              | Supervisor email  | Supervisor phone # |

| Section 2 - C1 Access Information  |  | <input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Suspend <input type="checkbox"/> Remove (check one) |  |
|--|--|---|--|
| Request Date   | Effective Date   | Expiration Date (If temp access)  |  |
| Requested Access<br><i>(to see a profile description, hover over the profile checkbox)</i><br><br><u>Provider Domain Name:</u> | <u>PROVIDER</u><br><input type="checkbox"/> Credentialing Specialist<br><input type="checkbox"/> EDI Team<br><input type="checkbox"/> View Only (inquiry)<br><input type="checkbox"/> Upload Files | <u>PROVIDER EHR</u><br><input type="checkbox"/> Incentive Specialist<br><i>(eMIPP system admin)</i>                                       | <u>PROVIDER SECURITY</u><br><input type="checkbox"/> Account Administrator<br><i>(account admin requires additional approval in Section 4 below)</i> |
| Justification for access (required)  |  |   |  |

| Section 3 - Security Agreement/Approvals (e-sign allowed)  |       |
|--|-------|
| <u>User Acknowledgement</u> - I agree to comply with the Utah Department of Health, Division of Medicaid and Health Financing PRISM Access Agreement (located at <a href="http://medicaid.utah.gov/become-medicaid-provider">medicaid.utah.gov/become-medicaid-provider</a> ) and all other policies that are appropriate to the system profile assigned for my use. |       |
| User Signature:  | Date: |
| <u>Provider Approval</u> - I attest the requested access profile is appropriate and necessary for this individual to perform his/her assigned job duties. I understand training on system use is the supervisor's responsibility. Any changes in this employee's job duties which impact system use will be promptly reported to our PRISM account administrator.    |       |
| Provider Signature:  | Date: |

| Section 4 – Account Administrator Agreement/Approval  |  |
|---|--|
| <u>User Acknowledgement</u> _____ (initial) I additionally acknowledge the Provider Account Administrator access profile is considered privileged access for the purpose of user management and includes other security duties such as, but not limited to, maintaining appropriate access documentation and performing activity reviews. |  |
| <u>Provider Approval</u> _____ (initial) I additionally authorize this individual to serve as the PRISM account administrator for my organization.  |  |

| Section 4 - for use by Provider Account Administrator |                |
|---|----------------|
| Completed by  | Date Completed |
| Reviewed by   | Date Reviewed  |
| Security Notes  |                |