



## Alliance Claims System (ACS) Provider Portal Access Request

This form is to be used to request a login and password for access to the Alliance Claims System

(ACS) Provider Portal. The form is also used to revoke an employee's access that is no longer working with your agency. A member of senior management is required to complete, sign and submit the form.

**Save time, submit online!**

Instead of completing this PDF, you can now submit this information online at [alliancehealthplan.org/forms/6](http://alliancehealthplan.org/forms/6).

### I. Provider information

1. Provider name

2. Contact name

3. Title (must be a member of senior management)

4. Direct phone

5. Contact email

### II. Grant/Revoke access

Please list the names and emails of folks in your organization who need access granted or revoked from the Alliance Claims System (ACS).

#### Desired action

#### INTERNAL USE ONLY

Name	Email	✓ Grant access	✗ Revoke access	Alliance employee initials	Date of action (mm/dd/yy)
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

Authorized Signature (sign or type)

Date (mm/dd/yy)

X

#### Authorization (internal use only)

Alliance IT approval

Date (mm/dd/yy)

X

### Submission instructions

**ONLINE:** If you submitted this information online, no additional steps are required.

**PAPER:** If you did not submit the online form, please save and/or scan the completed form and email it to [ACSSupport@AllianceHealthPlan.org](mailto:ACSSupport@AllianceHealthPlan.org).