

ABS Web Portal Access Application
Assigned IDs cannot be transferred to other Practices/Locations

To obtain access for SmartHealth member eligibility and claims information, all fields below should be completed and this application returned to ABS.

Please note, you will not be able to view information until your first claim is submitted.

Provider Name: _____ **Billing TIN:** _____

Practice/Facility Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Each Tax ID number can only have one administrator whose responsibility it is to notify ABS/SmartHealth of portal user additions, changes and terminations. Please name an administrator for the TIN above:

Administrator Name: _____

Email Address: _____ *(Email Address must be provided to receive ID)*

Telephone Number: _____

In the section below, identify the individuals who will need access to the ABS Web Portal. All individuals using the portal must include email/phone number to receive a user name and password. User names and passwords will be emailed to individual user. User names and passwords must not be shared.

1:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>
2:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>
3:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>
4:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>

**Please complete second page of this application for additional users.*

*By signing this form, the Administrator has agreed to sole responsibility on behalf of any of the users above that are given access to the ABS Web Portal System for SmartHealth eligibility and claims information. **BOTH SIGNATURES ARE REQUIRED***

_____	_____	_____
<i>Administrator Signature</i>	<i>Title</i>	<i>Date</i>
_____	_____	_____
<i>Provider/Officer Signature</i>	<i>Title</i>	<i>Date</i>

<p><i>Mail or Fax Completed Application to:</i></p> <p>ABS for SmartHealth 8220 Irving Road Sterling Heights, MI 48312</p> <p align="right">Fax: (586) 693-4346</p>	<p><i>If you have questions, please call:</i></p> <p align="center">888-492-6811</p>
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ABS Web Portal Access Application Additional Users
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Provider Name: _____

Billing TIN: _____

Practice/Facility Name: _____

In the section below, identify ADDITIONAL individuals who will need access to the ABS Web Portal. All individuals using this Portal must include email/phone number to receive a user name and password. User names and passwords will be emailed to individual user. User names and passwords must not be shared.

5:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>
6:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>
7:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>
8:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>
9:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>
10:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>
11:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>
12:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>
13:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>
14:	_____	_____	_____
	<i>Name (First, Last)</i>	<i>Email Address</i>	<i>Telephone #</i>