McLaren HEALTH PLAN

McLaren HEALTH ADVANTAGE

FACTSWeb
Request Form

Your Privacy is Important. McLaren Health Plan has a strict Privacy Policy, we will not share your account information with others.

All fields must be completed

Provider Name:	
Office Manager/Authorized Contact:	
Phone Number:	
Tax Id:	NPI:

Type of Access Requested: *Please only mark **ONE**	☐ Eligibility Inquiry	☐ Claim Status and Eligibility Inquiry* ***Only 1 person per Tax ID will have ability to request access for claims status inquiry**
First and Last Name:		
Position/Title:		
Address		
City, State, Zip		
Phone Number:		
E-mail:		

***Must use an individual email, please no company email addresses**

I hereby state that the information provide on this application is correct and pertains to my practice/facility only. On behalf of the requesting provider/facility, signer agrees to:

1. Acceptance of provisions outlined in the attached FACTSWeb Privacy and Security Guidelines.
2. To use data obtained only in the manner specified by McLaren Health Plan/McLaren Health Advantage.
3. To assure information obtained shall be kept confidential and only used for purposes related to transactions of McLaren Health Plan/McLaren Health Advantage.
4. Adhere to all confidentiality provisions of McLaren Health Plan/McLaren Health Advantage participation agreements, which are applicable to the individual user granted access to member and claim information via FACTSWeb.
5. If the User named on this request is no longer employed or does not require access to FACTSWeb, it is your responsibility to notify us immediately so access can be terminated.
6. Ensure that the individual designated by Provider to access FACTSWeb complies with paragraphs 1-5.

Office Manager/Authorized Contact Signature:
User Signature:
Date:

Fax completed form to:
(810) 733-9651

McLaren Health Plan Staff Use Only		
	Date	**Initials**
Receipt Date		
Completion Date		

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