



# Employer Portal Access Request Form

Group Name(s):

Group Number(s):

Please list all persons (including yourself) to be granted access/or terminated from access, to the PAI employer portal for the above mentioned PAI group account(s). Be sure to check the corresponding box to Grant or Terminate, each person listed.

By completing and submitting this form, I authorize, grant or terminate, as noted herein, access to the Employer Portal, for those person(s) noted below. In granting access I authorize those listed to perform as an administrator on behalf of the health benefit plan listed. This access grants all employer available actions related to participant protected health information. This access is necessary and meets the criteria for what is minimally necessary for the purposes of treatment payment or health care operations (TPO) of the health benefit plan. Access through the employer portal includes, but is not limited to, personal demographic information, medical claims, diagnosis information, explanation of benefits, etc.

I also understand once access for any user is no longer appropriate, that access will be terminated immediately by submitting this form, marked terminate, along with the user name.

Grant Terminate

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

I have full authority to grant this access.

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please email the completed form to your Account Executive.