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| **Provider Portal Enrollment** | | | | |
| The Pinnacle Health Group has developed this Provider Portal that will allow providers to submit patient cases directly to the Pinnacle Case Management Team for benefit verification and prior authorization. Enrolling in the portal will allow providers to enter cases and also check case status real time. A Business Associates Agreement (BAA) is required prior to exchanging protected health information (PHI).  Once this document is completed and submitted you will receive an email with portal login instructions and credentials. You will need to know the name of the company and the products you will be submitting patient cases for in order to complete this portal enrollment document. If you have questions regarding this process or form, please contact our Pinnacle team at 866-369-9290. | | | | |
|  | | | | |
| Provider Information: | | |  | |
| ***Practice or Facility Name:*** | | | ***Practice Phone Number:*** | |
|  | | |  | |
| ***Address*** | | | ***City/State*** | ***Zip*** |
|  | | |  |  |
| Company and Product(s) to be used: | | | | |
| ***Company Name*** | | | ***Sales Representative Name (If known)*** | |
|  | | |  | |
| ***Product(s) used*** | | | | |
|  | | | | |
| Primary Contact: | | | | |
| ***Contact Name*** | ***Phone Number*** | | ***Fax Number*** | |
|  |  | |  | |
| ***Email Address*** | | | | |
| **@** | | | | |
| Please indicate how you want patient benefits communicated to your office (check one): | | | | |
| Physicians affiliated with facility/office: *(Include physician degree i.e. MD, DO, PA-C)*  ***Note: PLEASE ENTER ALL PROVIDERS THAT WILL SUBMIT PATIENT CASES*** | | | | |
| **NAME** |  | **NPI** | **TAX ID** | **PTAN** |
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| **IF ADDITIONAL PROVIDERS WILL SUBMIT CASES (BEYOND THE 5 ENTERED HERE) PLEASE EMAIL** [**BV@THEPINNACLEHEALTHGROUP.COM**](mailto:BV@THEPINNACLEHEALTHGROUP.COM) **WITH THE ADDITIONAL PROVIDER NAMES, NPI, TAX ID AND PTAN** | | | | |

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