modivcare

Medical Provider Electronic Data Interchange (EDI) Forms

Dear Medical Provider:

Modivcare offers a secured web portal designed to allow medical facilities to request trips and standing orders from Modivcare electronically. Modivcare will provide two (or more upon request) administrative logins to the web portal for each medical facility. The medical facility administrators are required to manage access to the web portal for all other users at their facility.

To use the portal, you must register with our Facilities department. The attached user forms must be filled out, signed and faxed to the Modivcare Facility department you normally work with to request transportation services.

The Modivcare Facility department will call or fax the user login information to the user. Once your administrative users are setup, those users can create additional logins for other employees at your facility as needed.

Please return by fax to 1-866-269-8875

Medical Facility
EDI Administrator User Form

Please Type or Print Clearly

Date: _____

Facility Name:_____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

Medicaid Provider Number or NPI Number: _____

Access: Select one option:

- ☐ Add New Administrative User
- ☐ Inactivate Administrative User
- ☐ Password Reset

User Name: _____

User Email Address: _____

User Job Title: _____

_____

By signing this form, I hereby agree that:

- I will abide by all federal and state regulations pertaining to protected health information (PHI) including the Health Insurance Portability and Accountability Act ("HIPAA").
- I will only provide portal access to employees at my medical facility that have a need to request or review transportation requests.
- I will remove terminated users or users who no longer need access to the portal immediately.
- Modivcare may remove portal access for me or my medical facility at any time, with or without cause.
- I will use the system in accordance with Modivcare's documented instructions.
- I will not share my user ID or password with another user.
- I understand that the intentional entry of invalid or false information is unlawful and may have significant adverse legal repercussions.
- I will notify Modivcare immediately if I believe a security incident has occurred.

User Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness Name: _____Title:_____

(Witness must work at the same medical facility)

TO BE COMPLETED BY MODIVCARE FACILITY DEPARTMENT:

User ID Assigned: _____

Employee Completing Request: _____ Date Completed: