Online Claims Access Request

Use this form to request access to the online claims portal to view claims that have been repriced under your participation agreement with The Alliance.

Contact Information	
User's Name:	Title:
Group/Practice Name:	Tax ID:
Address:	Phone:
Name of Employer if different than Group/Practice:	
Email (required):	
I understand that I am requesting access to claims data that is protected under HIPAA, and that this data may not be used for any other purpose than that permitted by law. Unauthorized use or disclosure of this information may result in civil or criminal penalties. I agree to take appropriate measures to prevent unauthorized use or disclosure and to report any such unauthorized disclosure promptly. I further agree not to share my login information with any other person. Signature: Date:	

If the requestor is not the provider of services, this request must be signed by an authorized representative of the organization (manager, supervisor, director).

Authorization Information	
Name:	Title:
Email (required):	
I authorize the requestor to receive claims data on my/our behalf, and agree to notify The Alliance promptly of any changes to this authorization. Signature: Date:	

Please return completed form to:

THE ALLIANCE
Employers moving health care forward®

Attn: Provider Relations
PO Box 44365, Madison, WI 53744
Phone: 608.276.6620
Fax: 608.210.6677
Email: providerservices@the-alliance.org

FOR THE ALLIANCE USE ONLY:

Entered in Claims Portal_____