PROVIDER LOGON ID REQUEST FORM FOR CCAR TOOL

Please take a few minutes to complete this request form so that you and your staff can take full advantage of the services available to your organization through the Colorado Client Assessment Record (CCAR) tool.

Submit the completed form electronically by using the **SUBMIT** button on the last page of this document.

If you are having trouble with the submit button, save this document to your computer, complete it, and:

Return by email to: pns@coaccess.com	or	**Return by mail to:** Provider Relations PO Box 17580 Denver, CO 80217-0580	or	**Return by Fax:** 303-755-2368 Attn: Provider Relations

On the following pages, please list the name of the clinic or facility, and each of the staff clinicians who need of access to the CCAR.

- Each person will need their own login to access the secure application.
- Each person's login is specific to the Tax ID number submitted on this form. If you have staff members who need access for more than one Tax ID number, please submit forms for each applicable Tax ID number.
- Attach additional pages if needed.

OFFICE INFORMATION

Office/Clinic Name			
Date			
Tax ID Number (TIN)			
Address Line 1			
Address Line 2			
City, State, Zip Code			
Primary Contact		Email	
Phone		Fax	
Technical Contact		Phone	

USER INFORMATION

First/Last Name	
Position/Title	
Phone	
Email (required)	

First/Last Name	
Position/Title	
Phone	
Email (required)	

First/Last Name	
Position/Title	
Phone	
Email (required)	

First/Last Name	
Position/Title	
Phone	
Email (required)	

USER INFORMATION CONTINUED

First/Last Name	
Position/Title	
Phone	
Email (required)	

First/Last Name	
Position/Title	
Phone	
Email (required)	

First/Last Name	
Position/Title	
Phone	
Email (required)	

First/Last Name	
Position/Title	
Phone	
Email (required)	

First/Last Name	
Position/Title	
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First/Last Name	
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Email (required)	

First/Last Name	
Position/Title	
Phone	
Email (required)	

SUBMIT