Non-Physician Fee Schedule
Access Request Form – *Existing User*

OHIOHEALTH
Clinically Integrated
NETWORK

If you need fee schedule access for **more than one OhioHealth Clinically Integrated Network (CIN) participating practice,** please complete and submit a form for each unique practice.

APPLICANT INFORMATION					
Last Name:		**First:**		**M.I.:**	
Practice Job Title:			**DOB:**	__ /__ /____	
Email Address:					
Primary Phone Number:					

PRACTICE INFORMATION					
Practice Tax Payer Identification Number (TIN):	___ ___ ___ ___ ___ ___ ___ ___ ___				
Practice Name:					
Practice Street Address:					
Suite / Floor:		**City:**		**ZIP:**	

Please review/sign the disclaimer below. An OhioHealth CIN participating physician in your practice must sign this form to authorize this request.

APPLICANT DISCLAIMER AND SIGNATURE			
I understand that the financial terms of all OhioHealth Clinically Integrated Network (CIN) contracts are strictly confidential. I agree not to communicate financial information about OhioHealth CIN contracts to anyone other than my practice's office staff and professional advisors. I understand that I am not authorized to share OhioHealth CIN fee schedule information, and that **any dissemination of OhioHealth CIN fee schedule information to third parties may be a violation of the applicable federal and state antitrust laws**. I agree to keep any and all fee schedule information shared with me confidential, whether verbal, electronic or written. I recognize that disclosure of or sharing of login/access codes and passwords assigned to me is prohibited and that I am accountable for them and any improper access to information gained with these privileges. My access privileges are the equivalent to my legal signature and I shall take all reasonable and necessary steps to protect my access privileges. I acknowledge that I am responsible for all actions taken using those privileges. If I have reason to believe that the confidentiality of my access privileges have been broken, I shall immediately notify the Provider Network Coordinator at 614-566-0003 or 877-644-7469 (toll free).			
Signature:		**Date:**	__ /__ /____

PLEASE FAX (614-566-0433) OR EMAIL (TBlackmon@OhioHealthGroup.com) THIS FORM TO THE CIN PROVIDER NETWORK COORDINATOR

Updated May 2020

To complete this request form, an OhioHealth CIN participating physician(s) must authorize your access request by completing the fields and signing the disclaimer below.

AUTHORIZING PHYSICIAN INFORMATION							
Last Name:		**First:**			**M.I.:**		
Primary Phone Number:		**DOB:**	__ /__ /____	**OPID:**			
Email Address:							

AUTHORIZING PHYSICIAN DISCLAIMER AND SIGNATURE			
I authorize the applicant named on this request form to have access to OhioHealth CIN Fee Schedules. I certify that the applicant will be bound to any and all laws of the State of Ohio related to antitrust and data security. I will notify the Provider Network Coordinator at 614-566-0030 or 877-644-7469 (toll free) when the staff member's access needs to be terminated.			
Signature:		**Date:**	__ /__ /____

FOR OHIOHEALTH CIN INTERNAL USE ONLY			
Application is : Approved ☐ Denied ☐	**CIN / PSC Processor Notes:**		
CIN Processor Name:		**Process Date:**	
PSC Processor Name:		**Process Date:**	

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