moda HEALTH

MEDICAL ACCOUNT ACCESS REMOVAL REQUEST

As an authorized representative of _____(CLIENT), I hereby request that the following user names be deactivated and removed from our profile for use.

_____

_____

_____

_____

I understand that the above indicated user name(s) will remain on record internally with Moda Health Plan, Inc. (Moda Health) *for up to 7 years*. As an authorized representative I may request that the above indicated user names be restored, when requested in writing, with the appropriate signature at a later date if applicable.

_____
Printed Name

_____
Title

_____
Date

_____
Tax Identification #

_____
Signature

The individual signing on behalf of the Client must be a designated contact and previously approved under a Medical Electronic Services Agreement currently on file with Moda Health. We will also accept a signature from the owner of the business in a sole proprietorship, a partner in a partnership, or the designated principal in a limited partnership, corporation or other licensed entity. Examples include: Owner, Officer, Administrator, or Patient Accounts Director.

Return the signed request to:

Enterprise Benefit Tracker
C/O Moda Health Plan, Inc.
PO Box 40384
Portland, OR 97240-0384
Fax 503-948-5577
ebt@modahealth.com