

IDX System Security Access Request

I. (Required)

Department: _____ Group: _____

Division _____

User's Name: _____ Mnemonic: _____
First Name, Middle Initial, Last Name 3 - 4 letters

Location: _____ Tel No.: _____

User: ___ New ___ Revision ___ Deactivation (Delete PCS workfiles and DBMS queries? Y/N)

Did user have previous IDX access? (Y/N) _____ Indicate initials _____ Add to mailing list?

(Y/N) _____

II. Please check off/circle those functions this user will need.

A. BAR ___ Inquiry Only (Part Time) ___ w/Reports

B. PCS ___ User ___ Manager

___ Registration

C. TES ___ User ___ Manager

___ Charge Entry

D. DBMS ___

___ Payment Posting

E. E-Commerce ___

___ FSC Transfers Only

F. Clinic on TRAC ___ Profee ___

___ Supervisor (Ref., Disc, W/O's, Trans, M/E Rpt)

Role: _____

___ Manager (Global updates & Mgmt Reports)

Workgroup: _____

III. Please check off/circle those functions this user will need.

A. IDXTEND ___ IDXTEND (Scheduling)

B. MASTER SCHEDULING ___

___ IDXTEND (Scheduling w/Check -Out)

Access: ___ Inquiry only ___ Scheduler

(Restrict security to:)

Departments:

a. _____

b. _____

c. _____

d. _____

Providers:

a. _____

b. _____

c. _____

d. _____

IV. DEPARTMENTAL APPROVAL (Required)

An authorized person in requesting department must approve all requests. If a license fee is chargeable, authorized signature must have DAF rights. I understand that Federal Law requires all workforces to be HIPAA and ICA trained and represent by this request that this person has been HIPAA and ICA trained. In addition, under our Institutional Compliance Agreement with the Federal government, physicians, other providers and billing staff must attend annual compliance training. New providers and new employees involved in any aspect of billing must sign a Code of Conduct and attend a compliance training session within 30 days of starting work. If you have not received billing or HIPAA and ICA compliance training please call the Office for Billing Compliance, 212-305-3842.

Requested by _____

Date _____

Please print the name

Authorized Signature _____

Date _____

Entered by _____

For Support Center Use Only

Date _____

Fax (212) 342-0584