FinThrive

Access Request Form

Instructions

To comply with security and privacy regulations, FinThrive restricts and tracks access to healthcare data in our possession. This registration form assists us in that process by assigning a unique set of login credentials and access rights for each provider representative. All access requests or changes must be authorized and approved by a supervisor.

New User

1. Complete **New User Information** (section 1).

    a. *Your employee ID and/or a 4 digit pin of your choosing will be used for identity verification should you ever need to call us with a question about this account. Requests via email will use the email address as the verifier and confirmations will be sent to the user and supervisor email address on file.*

    b. *The email address MUST be a corporate email account. Personal email addresses are not allowed. All password resets, report notifications, etc. will be sent to this account.*

2. List the facilities you need access to in the **Access Details** (section 2). If you work at a central billing office and need to work reports for a number of facilities, please list them all here. Access should be restricted to the minimum necessary to perform assigned duties.

3. Read through the **Agreement** (section 3) which outlines your responsibilities and duty to protect both your account credentials, and patient data accessed with these credentials.

4. Finally, both you and your supervisor will need to complete and sign the **Acknowledgement of Agreement** (section 4).

Supervisor*

1. Please verify that the information presented is correct and read **Agreement** (section 3).

    a. *Is the user's business email address correct? (name@hospital.org)*
    b. *Have the correct facilities and reports been assigned to this user?*

2. Please sign in the Supervisor section of the **Acknowledgement of Agreement** (section 4).

3. Please return the completed form by secure email to: IDCustomerService@finthrive.com

    An email will be sent to the user with a link to reset their password and a confirmation email will be sent to the authorizing supervisor.

* *Please make sure that there is at least one employee assigned to review each billable report.*

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1. New User Information

Name (First, Middle, Last)	Title		Request Date
Company Name & Address	Work Phone Number	EXT	4 Digit Pin Number
User Type: ☐ HOSPITAL EMPLOYEE ☐ OTHER	Work Email Address		Employee ID

2. Access Details

Facilities for which access is requested:

☐ **Check this box for access to ALL FACILITIES in the system**

Report access requested (please check all that apply)

☐ **Check this box for access to ALL REPORTS**

Discovered Coverage Reports

☐ Medicaid Reports
☐ Medicare Reports
☐ TRICARE Reports
☐ Commercial Reports
☐ Coordination of Benefit (COB) Reports

Reimbursement Reports

☐ Medicare Advantage IME/GME Report
☐ DSH Days Listing

Management Reports

☐ Monthly Invoice Reports

Analytics

☐ Analytics Dashboards

3. Agreement

This authorization agreement should be signed by the User and his/her Supervisor requesting access and sent to FinThrive at the email or fax below. The signatures on this Agreement acknowledge the authorization of the individual user named above to have access to the services available through FinThrive's system. User IDs and Passwords will be assigned only for the specific access requested. Preserving the confidentiality of all individually identifiable health information that is transmitted or maintained by electronic media, or transmitted or maintained in any other form or medium is the responsibility of each individual that has access to FinThrive systems. All persons who have access to confidential and sensitive information must understand their personal responsibility to comply with all applicable laws and security policies. User IDs and passwords must be secure from unauthorized persons. Sharing this information is prohibited. All content available on FinThrive systems should be kept confidential and exclusive to those that require use of the system and should not be shared with any third-party individuals or used for any unauthorized purposes. Users and Supervisors should promptly notify FinThrive Insurance Discover Customer Service of any changes to authorized access, or any unauthorized use of FinThrive systems. Restrictions in this form are in addition to restrictions contained in the agreement between FinThrive and provider.

4. Acknowledgement of Agreement

Printed Name			
Signature			Signature Date
Printed Supervisor Name, Title	Work Phone Number	Ext	Work Email Address
Supervisor Signature			Signature Date

Please return the completed form by secure email to: IDCustomerService@finthrive.com. *(If you have questions about this form or agreement please contact Customer Service at (800) 553-6074).*