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Provider Portal New User Request

A separate Provider Portal Access Identification form is required for each User requested.
Please provide identifying information for the one individual that should be receiving access to the Provider Portal.

Provider Information

I am a:

☐ **Pharmacist** **NCPDP:** **Payee ID** Internal Use Only

☐ **Pharm Other** **NCPDP:** **Payee ID** Internal Use Only

☐ **Physician** **MD State License:** **DEA Number (if applicable):**

☐ **Other Provider Type** **Description:**

NPI For Practice Location:

Medicaid ID

User Name:

Last *First* *MI*

Pharmacy or Clinic Name:

Address:

Street Address

City *State* *ZIP Code*

Phone: **Alt. Phone:**

E-mail:

To the best of my knowledge the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health Division of Medical Assistance for the purpose of Accessing the Provider Portal. I understand that falsification; omission or misrepresentation of any information in this document will result in a denial of access to the Portal, possible closure of current provider members and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions.

I understand that my signature certifies that I am authorized to make binding decisions on behalf of the Provider/Facility listed above.

Medicaid/PeachCare Provider Signature: ______________________

Date: ______________________

Email (preferred) the completed registration form to GAMProvider.PortalTeam@optum.com
or Fax to 1-888-292-4814