Indiana Medicaid Provider Portal New User Request

A separate Provider Portal Access identification form is required for each user requesting access. Please provide identifying information for the individual that is requesting access to the Provider Portal.

Provider Information				
I am a:	☐	Pharmacist	State License:	
	☐	Pharmacy Technician	State License:	
	☐	Physician	State License:	
	☐	Other Provider	Description:	

Requestor's Name:			
	Last name	*First Name*	*MI*
Pharmacy or Clinic Name			
NPI of Practice Location:			
Address:			
	Street address		
	City	*State*	*Zip*
Phone:			
Alt. Phone:			
E-mail:			

To the best of my knowledge the information supplied in this document is true, accurate, and complete and is provided to OptumRx for the purpose of accessing the Indiana Medicaid Provider Portal. I understand that falsification, omission, or misrepresentation of any information in this document may result in a denial of access to the Portal.

My signature certifies that I am authorized to make binding decisions on behalf of the Provider/Facility named above.

Indiana Health Coverage Programs Provider Signature: /s/

Date:
mm/dd/yyyy

Please email this completed registration form to INMProviderPortalSupport@optum.com