Scott & White Health Plan

MyPlan Web Provider Module Sign On Request Form

Provider Name:____ SWHP Provider Number:___________________

National Provider Identifier #:____

Tax ID #____

Primary Contact Name for your office Sign On:

First Name: ________________________________Middle Name________________________________

Last Name: ____

Organization Name: ____

Email Address: ____ Phone: _______________________

Mailing Address: ____ City _______________________

State: _________ Zip: ______________ Main Office Phone Number: _______________________

On Line Services Requested for this Contact Person: **Claims or Eligibility or Both**
(Please Circle One)

Comments or Special Requests:
____
____
____

Supervisor's Name Authorizing this Sign On: ____

Phone: ____

Email Address: ___________________________________

Main Office Physician/Provider Contact Email address (if applicable): ____

SWHP Provider Relations and SWHP Claims Department

Panel ________

Verified Amisys Provider Number: ________________ Completed by: __________________ Date: _________________

MyPlan UserName: _____________________________ MyPlan Password: __________________________

Security Completed by: _____________ Date: _____________ Notified User: _________________________

Gray shaded areas will be filled out by SWHP Provider Relations.

(FAX COMPLETED FORM TO REBECCA CASTILLEJA/PROV REL AT FAX #254-298-3044)