

Scott & White Health Plan
MyPlan Web Provider Module Sign On Request Form

Provider Name: _____ SWHP Provider Number: _____

National Provider ID#: _____ (If applicable)

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 Administration and SWHP Claims Dept.

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 Administration.

(FAX COMPLETED FORM TO SWHP ADMIN., ATTN: IDA HICKS, FAX #254-298-3011)