IHP Request Form for Account Creation

Account(s) Request (select any of the following)**:**

☐ Patient Ping ☐ Wellcentive

Name (include credentials if applicable [MD, RN, BSN, CCM, MCM, etc.])

_____

Email address (specific to you only)

_____

Office Name (if applicable, please list all offices to be included to your account)

_____

User Type (select one of the following types):

☐ Clinical Support ☐ Care Manager

☐ Non-Clinical Support ☐ Office Manager

IHP STAFF USE ONLY

	Patient Ping	**Wellcentive**
☐ Account Creation Form Received	**Date:** _____	**Date:** _____
☐ Confidentiality Agreement Received	**Date:** _____	**Date:** _____
☐ Account Created	**Date:** _____	**Date:** _____
☐ User Notified	**Date:** _____	**Date:** _____
☐ User Account Terminated	**Date:** _____	**Date:** _____
	OM Notified: _____	**OM Notified:** _____

Please fill out one form for each office that you need access to. Each field is required and submitting an incomplete form will increase the time required to process your request.