

Provider Relations

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Senior Whole Health.
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Agency CaseTrakker Access Request Form

Agency Information		Date of request	
Name:		NPI number:	
Street address:		City:	State:
Zip code:	Primary phone number:		
SWH Provider Relation rep. name:		Date of Provider Relations receipt:	
Requester 1			
Name:		Email address:	
Title:		Phone number:	
Requester 2			
Name:		Email address:	
Title:		Phone number:	
Type of Request			
<input type="checkbox"/> CaseTrakker access	<input type="checkbox"/> Platform access	<input type="checkbox"/> Prospect side	<input type="checkbox"/> Live side
Primary requestor's signature			Date:
For administrative use only			
Date received:			
Action taken by Provider Relations:			Date:
Action taken by SWH IT:			
Privacy official signature (upon completion):			Date:
<i>If more than two persons in the agency will need access, attach additional documentation, if applicable.</i>			