

MEDICAL ACCOUNT ACCESS REMOVAL REQUEST

As an authorized representative of _____(CLIENT), I hereby request that the following user names be deactivated and removed from our profile for use.

I understand that the above indicated user name(s) will remain on record internally with ODS *for up to 7 years*. As an authorized representative I may request that the above indicated user names be restored, when requested in writing, with the appropriate signature at a later date if applicable.

Printed Name

Title

Date

Phone Number

Tax Identification #

Email Address

Signature

The individual signing on behalf of the Client must be a designated contact and previously approved under a Medical Electronic Services Agreement currently on file with ODS. We will also accept a signature from the owner of the business in a sole proprietorship, a partner in a partnership, or the designated principal in a limited partnership, corporation or other licensed entity. Examples include: Owner, Officer, Administrator, Patient Accounts Director.

Return the signed request to:
Enterprise Benefit Tracker
C/O ODS Health Plans
PO Box 40384
Portland, OR 97240-0384
Fax 503-243-4498
ebt@odscompanies.com