



PHYSICIAN SELF-SERVICE CENTER REGISTRATION

Please print this form and complete all of the information.
Please fax your completed registration form to **(512)421-4412**.

Name: _____
Phone: _____
Email: _____
Job Title: _____
Date: _____

Job Duties That You Perform Daily (Please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Check-In | <input type="checkbox"/> Insurance Follow-up | <input type="checkbox"/> Dictate Clinical Notes |
| <input type="checkbox"/> Appointments | <input type="checkbox"/> Schedule
Surgery/Procedures | <input type="checkbox"/> Maintain Medical Records |
| <input type="checkbox"/> Verify Eligibility | <input type="checkbox"/> Request Authorizations or
Referrals | <input type="checkbox"/> Perform Insurance Appeals |
| <input type="checkbox"/> Collect Copays | <input type="checkbox"/> Treat Patients | |
| <input type="checkbox"/> Bill Insurance | <input type="checkbox"/> Write Prescriptions | |

What is Your Primary Job Duty? (Please check one)

- | | | |
|---|---|--|
| <input type="checkbox"/> Check-In | <input type="checkbox"/> Insurance Follow-up | <input type="checkbox"/> Dictate Clinical Notes |
| <input type="checkbox"/> Appointments | <input type="checkbox"/> Schedule
Surgery/Procedures | <input type="checkbox"/> Maintain Medical Records |
| <input type="checkbox"/> Verify Eligibility | <input type="checkbox"/> Request Authorizations or
Referrals | <input type="checkbox"/> Perform Insurance Appeals |
| <input type="checkbox"/> Collect Copays | <input type="checkbox"/> Treat Patients | |
| <input type="checkbox"/> Bill Insurance | <input type="checkbox"/> Write Prescriptions | |

Clinic or Office Name and Address

Name(s) of Providers in Practice at your Clinic or Office

Provider(s) Tax ID(s) and Specialty (ies) List with Provider Name(s) in space provided

In the event we need to contact you, please type a question below that can be used to uniquely identify yourself: _____

Please type the answer to your answer here: _____

Please type a hint below to remember your question and answer: _____



I would like to perform searches for the following plans (please check all that apply):

- Seton Children's Health Insurance Plan (CHIP)**
- Seton STAR Plan (MCD)**
- Seton Employee Plans (EPN, Expanded EPN)**
- SETONCare Plus (Charity Program of the Seton Community Health Centers: Seton
McCarthy, Seton Kozmetsky and Seton Topfer)**
- MAP (Medical Assistance Program - CBRACKFQ or CBRACKFQX Groups)**
- Charity (CCHC, TCHC)**