Please Email Completed Form to support@cimplicitycares.com **OR Fax to** 1-866-949-2469

cimplicity
Confidence in care.

CIMplicity On-Boarding Checklist

☐ Please send me a link to schedule portal training.

☐ I prefer to receive fax notification only.

UCB Name:	UCB Email:

A. DEMOGRAPHIC

Practice Name:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	
Primary Contact:		

B. BENEFIT INQUIRY CREDENTIALS

Group Tax ID	Group NPI Number	Group PTAN Number

C. PRESCRIBERS

Provider Credentials are required to facilitate benefit inquires on your behalf.

First Name	Last Name	Title	NPI Number	State License

*Where can you find your PTAN?

1. The letter sent by your MAC (Medicare Administrative Contractors) when you enrolled
2. Visit https://pecos.cms.hhs.gov
3. Obtain from your Practice Administrator

D. PREFERENCES

Please respond to the following statements so the CIMplicity team may better assist you.

In addition to using the portal, I would like to receive results via fax.	☐ Yes	☐ No
I would like assistance from CIMplicity with Prior-Authorization.	☐ Yes	☐ No
I would like a monthly automatic re-verification of all Lyophilized Powder cases submitted	☐ Yes	☐ No
For my commercial patients only, run benefit investigation for both formulations if the formulation I originally chose is denied.	☐ Yes	☐ No

Select payer types for re-verification:	☐ All Payers ☐ Commercial Payers Only ☐ Government Payers Only	Frequency of re-verification: ☐ 1st week of the month ☐ 3rd week of the month

E. USERS

Provide the name and email address for additional user accounts.

First Name	Last Name	E-mail Address

F. ADDITIONAL LOCATION

Provide demographic for additional location(s) that are part of your practice.

Practice Name:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	

G. ADDITIONAL PRESCRIBERS

Use this page to list any additional Prescribers.

First Name	Last Name	Suffix	Email	Prescriber Tax ID	Prescriber NPI	Prescriber PTAN

H. MULTI-SITE DEMOGRAPHICS

Provide demographics for additional Practices.

Practice Name:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	
Practice Name:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	
Practice Name:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	

I. Notes

Use this space to provide our support team with any additional information that may be important for us to know when setting up your practice.