PROVIDER ELECTRONIC DATA INTERCHANGE (PEDI) ACCOUNT REQUEST

Submit Form: Fax: (916) 440-5346 or
Scan and email: cmshelp@dhcs.ca.gov

Questions? Contact the CMS Net Help Desk
(866) 685-8449 or cmshelp@dhcs.ca.gov

This form is to be used by providers and health plans to request access to requests for service/service authorization information in PEDI. When the "Add" option is selected the user will be assigned a new User ID and temporary password. The form is also to be used to request modification or deactivation of a user ID. Please type or print legibly.

Provider Facility/Plan Name: _____

Select One	Name (Last, First)	Email Address	Position Title	Phone (999)999-9999
☐ Add ☐ Modify ☐ Delete				
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Liaison's Name (Print): _____ Phone: _____

Liaison's Name (Signature): _____ Date: _____

PEDI CONFIDENTIALITY OATH

As a condition of obtaining access to information concerning procedure or other data and records utilized/maintained by the State Department of Health Services, I agree not to divulge any information obtained in the course of my assigned duties to unauthorized person, and I agree not to publish or otherwise make public any information regarding person(s) enrolled in the California Children's Services (CCS) or Genetically Handicapped Persons Program (GHPP) such that the persons who received such services are identifiable.

Access to such data shall be limited to state and federal personnel who require the information in the performance of their duties, and to others such as providers and health care plans as may be authorized by the Department of Health Services.

I recognize that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

Provider Facility/Plan Name: _____

Printed Name of Staff	Staff Signature	Date

INSTRUCTIONS

Provider Facility/Plan Name:	The name of the provider facility or plan submitting request.
Select One:	
Add:	Select check box if this request is for account activation.
Modify:	Select check box if this request is for account modification.
Delete:	Select check box if this request is for account deactivation.
Name (Last, First):	Type user's last name, then user's first name.
Email Address:	Type user's email address.
Position Title:	Title of user's position.
Phone:	Type user's phone number, including area code (and extension if applicable) in format (999)999-9999.
Liaison's Name (Print):	Type the name of the liaison for the provider facility/plan.
Phone:	Type the Liaison's phone number, including area code (and extension if applicable).
Liaison's Name (Signature):	Signature of liaison.
Date:	Date account request was signed by the liaison.

Provider Facility/Plan Name:	The name of the provider facility or plan submitting request.
Printed Name of Staff:	Name of user with the "Add" option selected. Each user with the "Add" option selected must be listed and sign the confidentiality oath.
Staff Signature:	Signature of user with the "Add" option selected.
Date:	Date user with "Add" option selected signed the form.