ILLINOIS DEPARTMENT OF Healthcare and Family Services

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)
Provider Portal Administrative User Request Form

Submit Completed Requests to the IM-Assist Help Desk at ***OMI.CANSAccount@uillinois.edu***

Part One – Agency Information ***(required)***

Provider Agency Name:

Provider Agency Address:

Provider HFS Provider Identification Number:

National Provider Identifier Number:

Part Two – Notes

Part Three – User Information ***(required)***

User Type: ◯ Primary Administrative User ◯ Secondary Administrative User

Request Type: ◯ New Request ◯ Change Request

Name:

Email Address:

Phone Number

Part Four – User Agreement ***(required)***

I, the undersigned, certify that I am, or am employed by, an Illinois Department of Healthcare and Family Services, henceforth the Department, enrolled provider. I also certify that I have been authorized to create and maintain user accounts in the IM+CANS Provider Portal for those employed by my provider agency. Further, I understand that State and Federal laws and Department policy prohibits disclosure or discussion of any recipient information or other confidential information with anyone outside the Department or my provider agency without authorization. I understand that any unauthorized use of the IM+CANS Provider Portal is strictly prohibited.

Further, I am hereby advised and understand the requirements for non-disclosure of any confidential retention of all passwords or password information acquired by me whether such information pertains to my individual password or the password(s) of others. I will exercise diligence in the safekeeping of password information and will report authorized disclosure promptly to management at my provider agency and to the Department.

Requestor's Name *Requestor's Signature* *Date*