

Practice Manager Designee Form



Provider Portal Account Request Supplementary Form

Required Information (to be completed by group medical director)

Practice Name _____
Practice Street Address _____
Practice City _____
Practice State, ZIP _____

The medical director may designate a practice manager to assist with managing myUNM Health Provider Portal accounts for the practice group.

Designated myUNM Health Provider Portal Practice Manager

Last Name _____ **First** _____ **Middle** _____ **Suffix** _____
Title _____
Business Email _____
Signature _____ **Date** _____

Medical Director

Last Name _____ **First** _____ **Middle** _____ **Suffix** _____
Title _____
Business Email _____ **Phone** _____
Signature _____ **Date** _____

I authorize the practice manager designated above to approve or deny new myUNM Health Provider Portal accounts, verify providers employed by the practice, authorize extended access for existing myUNM Health Provider Portal account holders, and serve as point of contact for UNM Health when communicating with the practice.