## SEAMO CabMD Access Request Form Instructions

Please complete all questions on this form as completely and accurately as possible to insure that your request for access is processed in a timely manner.

Incomplete forms will be returned to the originating department.

1. Authorization must come from each individual **physician** where access is being requested (please note that physicians MUST sign the request form personally – no substitute signatures).

2. A completed request form includes the signature of the physician, the external billing agent and the Department Head.

3. **Please forward, via email, the signed copy of the request form to seamo.communication@queensu.ca.**

If you have any questions or concerns regarding the completion of this form, please contact SEAMO at 613-533-6000 ext. 75963.

***Please note, if you are uncertain which specialties you are registered in with OHIP, contact OHIP Service Contact Support at: 1-800-262-6524 or **providerregistration.MOH@ontario.ca.***

# SEAMO CabMD Enterprise Edition Application
# Access/Change Request Form — AGENT

| External Billing Agent Information (Full legal name required - please print) | | |
|---|---|---|
| Last Name | First | Middle |
| Street Address of business | | Apartment/Unit # |
| City | Prov. | Postal Code |
| Phone | E-mail Address | |

Account New Account ☐ Existing Account ☐ Change to Existing Account ☐

Access Type Internal KGH Network ☐ External Web Access (citrix) ☐

Date access required: Departmental Assistant access form approved YES ☐ NO ☐

| Physician Information (Full legal name required - please print) | | Date |
|---|---|---|
| Last Name | First | Middle |
| Street Address of Business | | Apartment/Unit # |
| City | Prov. | Postal Code |
| Phone | E-mail Address | |
| OHIP Provider Number | Provider College Number | |
| Job Title | Department | |

| | | | | | |
|---|---|---|---|---|---|
| Status | Part Time ☐ | Full Time ☐ | Temp ☐ | Contract ☐ | Casual ☐ |
| Site | KGH ☐ | HDH ☐ | PC ☐ | Other ☐ | Specify: |
| Account | New Account ☐ | Change to Existing Account ☐ | | | |
| MC EDT Email | | Password | | | |
| Access Type | Internal KGH Network ☐ | External Web Access (citrix) ☐ | | | |
| Date Access Required: | | | | | |

# SEAMO CabMD Enterprise Edition Application Access/Change Request Form — AGENT

| Registered Physician Specialty: (check all that apply) * | | |
|---|---|---|
| ☐ Anesthesiology (01) | ☐ Cardiology (60) | ☐Cardiovascular and Thoracic Surgery (09) |
| ☐ Clinical Immunology (62) | ☐ Dermatology (02) | ☐ Emergency Medicine (12) |
| ☐ Endocrinology & Metabolism (15) | ☐ Family Practice (00) | ☐ Gastroenterology (41) |
| ☐ General Surgery (03) | ☐ Genetics (22) | ☐ Geriatrics (07) |
| ☐ Haematology (61) | ☐ Infectious Disease (46) | ☐ Internal Medicine (13) |
| ☐ Medical Oncology (44) | ☐ Nephrology (16) | ☐ Neurology (18) |
| ☐ Neurosurgery( 04) | ☐ Obstetrics (20) | ☐ Oncology (74) |
| ☐ Ophthalmology (23) | ☐ Orthopaedic Surgery (06) | ☐ Otolaryngology (24) |
| ☐ Pathology (28) | ☐ Paediatrics (26) | ☐ Physical Medicine (31) |
| ☐ Plastic Surgery (08) | ☐ Psychiatry (19) | ☐ Respiratory Diseases (47) |
| ☐ Rheumatology (48) | ☐ Thoracic Surgery (64) | ☐ Urology (35) |
| ☐ Vascular Surgery (17) | ☐ Other: please specify: | |

| Signatures | |
|---|---|
| Physician Signature | Date |
| External Billing Agent Signature | Date |
| Department Head Signature | Date |

| To be completed by SEAMO - internal use only: | |
|---|---|
| Primary Department | Group |
| Additional Department | Group |
| Additional Department | Group |
| Additional Department | Group |
| Additional Department | Group |
| Additional Department | Group |