

SOONERCARE PROVIDER PORTAL ACCESS FORM

**** IF YOU ARE NOT THE PORTAL ADMINISTRATOR ADD THE PROVIDERS EMAIL TO THE REQUEST. ****
IF YOU ARE A CLERK DO NOT USE THIS FORM.

Date: _____ Requester Contact Name: _____

Contact Number: _____ Email Address: _____
(include area code)

By checking this box, you acknowledge and agree that you have been authorized and have legal authority to request secure account information on behalf of said provider. In no event will Gainwell Technologies be liable for any losses or damages including without limitation, indirect or consequential losses or damages arising from this request.
Note: this request will not be processed if the acknowledgment box above is not checked.

- Once completed, save the PDF and attach to an email, send to: SoonerCareInternetHelpDesk@dxc.com. Fax option is no longer available.
- Requested information will be emailed to the appropriate contact on file.

PLEASE ALLOW A MINIMUM OF 48 HOURS FOR PROCESSING.

Reason for Request: (check all that apply)			
User ID	Temporary Password	Challenge Questions	Pin Letter
Individual or Group Name:			
Provider Email:			
Individual or Group SoonerCare Provider #: (Example: 100000000A)		Individual or Group NPI:	
Provider SSN or Tax ID:			
Service location (complete street address, city, state, and zipcode):			

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